**HEALTH SURVEILLANCE**

**LASER WORKERS**

|  |  |
| --- | --- |
| Full Name: |  |
| Date of Birth: |  |

Please complete the following by indicating ✓ in the appropriate box.

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Have you previously worked with lasers? |  |  |
| If ‘Yes’ please give further details: | | |
| Place: | | |
| Length of Stay: | | |
| Class of Lasers: | | |

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Have you been subject to any accidental exposure? |  |  |
| If ‘ Yes’ please give further details: | | |
|  | | |
|  | | |

|  |
| --- |
| Present work: |
| Department: |
| Class of Lasers: |

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Have you read/ seen the Health and Safety information supplied? |  |  |
| Are you aware of the necessary precautions needed, including personal protective equipment? |  |  |

The information supplied by you on this questionnaire will be used to produce a certificate. This will be forwarded to your line manager/supervisor as evidence of your fitness to work/study.

|  |  |  |
| --- | --- | --- |
| Name: | Signature: | Date: |

**HEALTH SURVEILLANCE**

**LASER WORKERS**

|  |
| --- |
| Review Questionnaire Comments: |

|  |  |  |
| --- | --- | --- |
| **Keystone Vision Screening (attached)** |  |  |
|  | **Right** | **Left** |
| Acuity unaided: |  |  |
| Acuity aided: |  |  |
| Type aid to vision: | | |
| Field of vision: | | |
| Colour vision:(city university) | | |

|  |  |  |
| --- | --- | --- |
| Referral to Occupational Health Physician: | **Yes** | **No** |
| Comments/Reason: | | |

|  |  |
| --- | --- |
| Signature (OHN): |  |
| Signature (OHP): |  |
| Date: |  |

**Laser Certificate completed and sent to the laser Safety Coordinator: Mark Schmidt**