THE UNIVERSITY OF CHICAGO | Research, Innovation and National Laboratories
Office of Research Safety

Initial Laser Training Certification Form

Laser User Information	
Name (Last, First, MI):	CNetID:
Email:	Lab Phone:
Over 18 years old? ☐ Yes ☐ No	Position: ☐ Graduate ☐ Undergraduate ☐ Technician ☐ Faculty ☐ Other: _____

Please check all that apply:

☐I am a new user and completed Laser Safety Training on: _____

☐The Principal Investigator has asked me to be the Designee of the laboratory's lasers and laser systems.

☐I am transferring from Dr. _____'s lab to Dr. _____'s lab.

☐I will be working in Dr. _____'s lab in addition to this PI's lab.

☐I have read and understand the University of Chicago Laser Safety Program Policies and Procedures.

By signing this document, I declare that I have completed the University's Laser Safety Training requirements on the indicated dates. I also declare that I have been provided training on the procedures and hazards of the laser and laser systems in my workplace. I agree to ensure the safe use of lasers in the laboratory.

Signature:	Date:

Principal Investigator (PI) Information, Agreement, and Signature
PI Name (Last, First, MI):

By signing this document, I agree to take supervisory responsibility for this user and ensure the safe use of lasers in the laboratory and provide laboratory procedures specific to our lab and lasers.

Signature:	Date:

Submit completed form with the Initial Laser User Ocular History Questionnaire Form to the Laser Safety Officer at radsafety@uchicago.edu or fax (773) 702-4008.

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Ocular History Questionnaire Form

Laser User Information	
Name (Last, First, MI):	CNetID:
Have you worked with or near lasers anywhere other than at the University of Chicago? ☐ Yes ☐ No	
If yes, list location(s):	

Ocular History

Do you currently or have you ever been treated for (check all that apply):

☐Wear prescription lenses	☐Dryness	☐Lazy Eye
☐Wear sun glasses	☐Excess tearing/Watering	☐Loss of vision
☐Wear contact lenses	☐Eye Infection	☐Migraines
☐Blurred vision	☐Eye injury	☐Mucous discharge
☐Burning sensation	☐Eye pain/Soreness	☐Prominent Eye(s)
☐Cataracts	☐Flashes/"Floaters" in vision	☐Redness
☐Chronic infection of eye or lid	☐Foreign body sensation	☐Retinal Disease
☐Crossed eyes	☐Glare/Light sensitivity	☐Sandy or Gritty feeling
☐Distorted vision/Halos	☐Glaucoma	☐Seizures
☐Double vision	☐Headaches	☐Styes or Chalazion
☐Drooping Eyelid(s)	☐Itching	☐Tired eyes

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