

**APPENDIX A**

**WILLIAMS COLLEGE**

**AUTHORIZED LASER RESEARCHER APPLICATION**

SECTION I: INFORMATION

Date: \_\_\_\_\_

1. Name: \_\_\_\_\_  
(Print) Last First M.I.

2. Social Security Number: \_\_\_\_\_ Title: \_\_\_\_\_

3. Department \_\_\_\_\_

4. Office: \_\_\_\_\_ Ext.: \_\_\_\_\_

5. Laboratory \_\_\_\_\_ Ext.: \_\_\_\_\_

6. Description of laser and work involving lasers:

LASER Type: \_\_\_\_\_ Classification: \_\_\_\_\_

Description (include safety precautions):

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(If more space is needed, attach extra page.)

SECTION II: PREVIOUS EXPERIENCE WITH LASER(S)

1. Previous experience with laser(s):

Laser Type: \_\_\_\_\_ Classification: \_\_\_\_\_

Description:  
\_\_\_\_\_

2. Have you had any exposures to laser radiation in amounts known (or suspected) to be above the ANSI Z136.1-1986 maximum permissible exposure?

Yes: \_\_\_\_\_ No: \_\_\_\_\_ Unknown: \_\_\_\_\_

3. I have received and read the Laser Safety Handbook regarding the use of lasers at Williams College. I agree to comply with all applicable rules and regulations governing the safe use of lasers at Williams College.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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SECTION III: APPROVAL

1. Application Approved \_\_\_\_ Disapproved \_\_\_\_ Date: \_\_\_\_\_

2. Medical Surveillance Recommended:

(a) Eye Examination: \_\_\_\_\_ (b) Other: \_\_\_\_\_

3. Comments:  
  
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SECTION IV: TERMINATION (to be completed by LSO)

1. Date: \_\_\_\_\_

2. Medical Surveillance Recommended:

(a) Eye Examination: \_\_\_\_\_ (b) Other: \_\_\_\_\_  
\_\_\_\_\_

3. Comments:

Signed: \_\_\_\_\_