

Radiation Protection Program

SECTION I. Information		<input type="checkbox"/> MIT Campus	<input type="checkbox"/> MIT Lincoln Laboratory
Laser Worker	Last, First name	MIT ID/LL Badge #	Phone # email
Department/ Group	Supervisor/Group Leader	PI/Project	Last, First name
RP Approval (last, first name)	Signature	Date	
SECTION II. Instruction			
<p>The ANSI Standard (ANSI Z136.1) has made baseline and termination eye exams optional. Eye Exams are required for incidents or for cause conditions. MIT does encourage baseline Eye Examinations for open beam class 4 laser systems.</p> <p>Eye Exams administered by the MIT Medical Department (E23).</p> <ol style="list-style-type: none"> Contact the MIT Eye Clinic at 617-258-9768 to schedule an appointment for the Laser Eye Examination. Bring this form with you to your eye examination appointment. Obtain the Examiner's signature for verification. Return this form, signed by the Examiner, to the Radiation Protection Program within EHS. <p>Eye Exams administered by an external provider.</p> <ol style="list-style-type: none"> Provide a copy of the laser eye exam procedure in advance of the eye exam. (available for download on the EHS Radiation Protection Websites) Bring this form with you to your eye examination appointment. Obtain the Examiner's signature for verification. Return this form, signed by the Examiner, to the Radiation Protection Program within EHS. <p>Upon termination of work with Class 3B and/or Class 4 laser systems, you may also obtain a Termination Eye Examination by completing this form.</p> <p>NOTE: In the event of any accidental or suspected eye exposure to laser radiation, seek Medical Attention immediately. This form is not required for this. Have your supervisor initiate the supervisory injury process. MIT Medical Department may follow-up if initial care is not provided at MIT Medical Department. Notify the Radiation Protection Program for a review of the incident.</p>			
Eye Exam Type: <input type="checkbox"/> Baseline <input type="checkbox"/> Termination <input type="checkbox"/> Incident			
TO BE COMPLETED BY EXAMINER			
<input type="checkbox"/> MIT Medical			
Examiner (Print Name)	Signature	Date	
<input type="checkbox"/> External Provider:			
Company/Provider Organization Name _____			
Address: _____		Phone: _____	
Examiner (Print Name)	Signature	Date	