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## Laser Registration Form

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*All Class 3B and 4 lasers must be registered with the Florida Department of Health Bureau of Radiation Control within 30 days of acquiring them. By filling out this form, UCF EHS can assist you with registration of your laser and documentation to the FDOH BRC. Please contact the Laser Safety Officer at 407-823-3747 for any questions related to this form.*

### **Principal Investigator Information:**

Name: \_\_\_\_\_ Primary Department: \_\_\_\_\_

Affiliated Department: \_\_\_\_\_ Phone: \_\_\_\_\_ Lab Phone: \_\_\_\_\_

After Hour Phone: \_\_\_\_\_ UCF Email: \_\_\_\_\_

### **Lasers Information:**

Building: \_\_\_\_\_ Room: \_\_\_\_\_

Laser Manufacturer: \_\_\_\_\_

Model Number: \_\_\_\_\_

Serial Number: \_\_\_\_\_

Laser Type (ND:YAG, etc.): \_\_\_\_\_

Classification (3B or 4): \_\_\_\_\_

Operational Wavelengths (nm): \_\_\_\_\_

Beam Diameter (mm): \_\_\_\_\_

Beam Divergence (mrad): \_\_\_\_\_

Average Power (W): \_\_\_\_\_ Max Power (W): \_\_\_\_\_  Continuous Wave


Joules/Pulse: \_\_\_\_\_ Pulse Width (sec): \_\_\_\_\_  Pulsed

Repetition Rate (Hz): \_\_\_\_\_  Q-Switched

Briefly explain the purpose and use of this laser in your research:

**Protective Eyewear**

Is protective eyewear present for all lab workers and visitors?  Yes or  No

Link to online calculator for determining laser hazards including OD levels: 

Calculated Ocular MPE in Watts/cm<sup>2</sup>: \_\_\_\_\_

Calculated Optical Density (OD) for protective eye-wear and laser danger sign: \_\_\_\_\_

Calculated diffuse Nominal Hazard Zone (NHZ) in meters: \_\_\_\_\_

Calculated intrabeam Nominal Optical Hazard Distance (NOHD) in meters: \_\_\_\_\_

**Standard Operating Procedures**

Are standard operating procedures for the device(s) available?  Yes or  No

**Authorized Laser Users Information**

| Name | Laser Safety Training Date | SOP read and signed | Name | Laser Safety Training Date | SOP read and signed |
|------|----------------------------|---------------------|------|----------------------------|---------------------|
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I certify that the information provided above is true and correct.

**Principal Investigator:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**EHS Radiation Safety:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Email completed form to: [Renee.Michel@ucf.edu](mailto:Renee.Michel@ucf.edu)