



Harvard University *Environmental Health and Safety*

**SEAS AND EPS PERSONNEL**  
**Instructions for Completing Pre-Assignment**  
**Laser Eye Examination**

The Harvard University Health Services Eye Clinic provides baseline eye examinations for laser users of class 3B and 4 laser systems in accordance with the Massachusetts Department of Public Health and Harvard University Radiation Protection Office requirements. They are located at 74 Mt. Auburn Street, Holyoke Center, 5<sup>th</sup> Floor. A baseline laser eye examination must be completed prior to work with class 3B and 4 laser systems.

- Complete the examination form signed by supervisor or Principle Investigator.
- Forward (or bring) completed form to Lenny Solomon (5-4215, solomon@harvard.edu, fax-5-4902) to obtain a Harvard billing code.
- Schedule an appointment at University Health Services/Eye Clinic **(617) 495-2056**
- After having the eye exam, mail or fax the form with the UHS certification to:

**EH&S Radiation Protection Office**  
**46 Blackstone Street**  
**Cambridge, MA 02139**  
**Fax: (617) 496 - 5509**

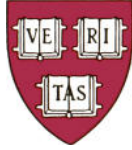
*and*

**fax to Lenny Solomon (617) 495-4902**

Harvard University **Environmental Health and Safety Radiation Protection Office**

Tel 617-495-2060 Prompt #2

[www.uos.harvard.edu/ehs/rad](http://www.uos.harvard.edu/ehs/rad)



## Pre-Assignment Laser Eye Examination

I have determined that [ \_\_\_\_\_ ] will work with or around Class 3B or greater laser systems under my supervision and that a baseline eye examination is required by MA Regulations and ANSI Z136-2000, Appendix E, before work can begin. The examination must include:

- Ocular History
- Visual Acuity
- Amsler Grid Test
- Color Vision
- Ocular Fundus (If any of the above exam results are abnormal)

I understand that the cost of this eye examination will be paid by the employee's department. The following department billing code will be applied to the invoice:

Department Billing Code:

\_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Print Supervisor or Principal Investigator's Name:

\_\_\_\_\_

Department: \_\_\_\_\_ Telephone: \_\_\_\_\_

Signature of Supervisor or Principal Investigator:

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

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***Completed by University Health Services***

I have performed the required eye examination on: \_\_\_\_\_ and the exam meets requirements for working with lasers.

Signature of Health Care Provider Date:

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