Western University
Staff / Faculty Health Services

Medical Surveillance Program for Western Staff and Faculty

Working with Laser Devices

Waiver

I have been informed and understand the potential risks to my vision from direct exposure to laser light. I have been informed and understand that I may participate in a medical examination and surveillance program designed to monitor and protect my vision. I have elected **not** to participate in this program and I release the Western University Staff / Faculty Health Services and its staff for any and all liability for any injury I might sustain in working with a laser device.

Name (print) _____ Date _____

Signature _____

Supervisor's name _____ Date _____

Supervisor's signature _____

Please FAX a copy of this completed form to Staff / Faculty Health Services at 519-661-2016.