

UNIVERSITY OF NEVADA, LAS VEGAS  
RADIOLOGICAL SAFETY OFFICE  
4505 MARYLAND PARKWAY, LAS VEGAS, NEVADA 89154-1042  
Phone (702) 895-4226 FAX (702) 895-4690

**Laser Incident Report**

Reported By: \_\_\_\_\_ Date: \_\_\_\_\_  
Department: \_\_\_\_\_ Office: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

**INCIDENT INFORMATION:**

Date of Incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_  
Location of Incident: \_\_\_\_\_  
Laser System of Incident: \_\_\_\_\_  
(Make, Model, Serial Number, Type, Wavelength, Power, Class)

Has this incident been reported to the Department Head?  Yes  No  
Has this incident been reported to the Laser Safety Officer?  Yes  No  
Did this incident involve eye exposure?  Yes  No  
Did this incident involve skin exposure?  Yes  No  
Was medical treatment sought for an injury?  Yes  No  
How long after the incident? \_\_\_\_\_

**INCIDENT DESCRIPTION** and action taken (add typed narrative on an attached page if necessary):

Has this incident occurred before in connection with this research?  Yes  No  
If yes, explain below.

Do you or your workers have any unanswered questions concerning any health effect originating from the incident?  Yes  No

If this work is supported by a research grant provide: grant title, funding agency, and RLU.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of LSO: \_\_\_\_\_ Date: \_\_\_\_\_