FLORIDA DEPARTMENT OF HEALTH

LASER DEVICE REGISTRATION FORM

(PLEASE SUBMIT A SEPARATE FORM FOR EACH SEPARATE LOCATION)

DOH Radiation Control
4052 Bald Cypress Way, Bin C21
Tallahassee, FL 32399-1741
(850) 245-4266

NAME OF REGISTRANT:_____ **PHONE** (____) ____ - ____ **EXT.**_____

STREET:_____ **CITY**_____ **STATE**____ **ZIP**_____ **COUNTY**_____

ADDRESS OF LASER DEVICES (IF DIFFERENT FROM ABOVE)_____

STREET:_____ **CITY**_____ **STATE**____ **ZIP**_____ **COUNTY**_____

NAME OF LASER SAFETY OFFICER:_____ **PHONE** (____) ____ - ____ **EXT.**_____

STREET:_____ **CITY**_____ **STATE**____ **ZIP**_____ **COUNTY**_____

ARE THESE LASERS PART OF A FIXED FACILITY OR ARE THESE MOBILE LASERS? **FIXED FACILITY** ☐ **MOBILE LASERS** ☐

DESCRIPTION OF LASER DEVICES AT THIS LOCATION

MEDIUM (Argon, CO_2, Nd:YAG, etc.)	**CLASS** (IIIB or IV)	**TYPE** (CW or Pulsed)	**WAVE LENGTHs** (nm)	**MAXIMUM OUTPUT** (Watts or Joules)	**MANUFACTURER**	**MODEL**	**SERIAL**	**USE** (Medical, Construction, Industrial, Research, Entertainment, or Other)

FOR OFFICE USE ONLY

SIGNATURE OF REGISTRANT:_____ **DATE:**_____ **REGISTRATION #:**_____

NAME & TITLE :_____ **EVALUATOR:**_____

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