THE UNIVERSITY OF MISSISSIPPI
LABORATORY SERVICES

Phone (662) 915-5433 FAX (662) 915-5480

MEDICAL TESTING CERTIFICATION FOR LABORATORY WORKERS

I certify

- that I am a duly authorized official of the _____ department, and,
- the attached reimbursement claim for _____, is in all respects true and correct, and the expense was solely for the benefit of the University, and ,
- the purchase was made in accordance all policies and laws of the State of Mississippi.

I understand that any obligation incurred by an employee of the University contrary to the policies and laws of the State of Mississippi are the personal obligation of the employee, and are not reimbursable by the University.

I hereby make application for the reimbursement to the individual indicated on the attached Request for Payment form.

Name / Signatory Officer :	Signature & Date
Department :	Office Phone #
Description of medical service : ☐ Baseline eye exam for a laser operator ☐ Respirator Fit Testing and Medical Evaluation with Spirometry ☐ other, description	

RECOMMENDATIONS / NOTES:

LASER SAFETY OFFICER:	**DATE:**