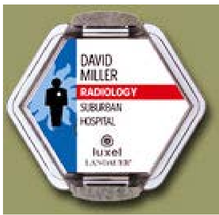

EHS ONLY	
Temp No. ________	Badge No. ________
Type: ________	Type: ________
Date: ________	Date: ________

RADIATION DOSIMETER APPLICATION

Name:
Credential (e.g. M.D. RT, RN, etc.)
Title:
University Computing ID (e.g. dps3c):
Sex: ☐ M ☐ F
Date of birth:
Department:
Place of work: room number, and building:
Phone number:
Name of supervisor:

Radioactive material use: Please check below the radioactive material that you will be working with and indicate **approximate** total activities to be used **per month:**

☐ P-32:
☐ I-131:
☐ Cs-137/Co-60
☐ Other nuclide(s) (mCi per month):
☐ I-125:
☐ F-18:
☐ Tc-99m:
☐ None

X-ray producing equipment use: Check all that apply; otherwise check "None."

☐ Diagnostic X-ray unit
☐ Fluoroscopy unit
☐ Portable or stationary C-arm
☐ CT
☐ Mammography
☐ DEXA
☐ Other
☐ None

PREVIOUS EMPLOYMENT HISTORY INVOLVING RADIATION EXPOSURE:

Have you previously worn a dosimeter at UVA? ☐ Yes ☐ No
If yes and a dosimeter was issued to you under a different name, provide that name:

If you have worn a dosimeter at another institution please provide the following information:

Company Name	Street	City, State	Zip Code	Dates

***I certify** that the information given on this application is correct and complete to the best of my knowledge. I hereby authorize my previous employers to release my dosimetry records to the Radiation Safety Office, University of Virginia.*

SIGNATURE: ______________________________ DATE: ____________________

Rev. 1, 7/19