



Dosimetry Request Form

New

Restart

Personal Data

Name _____ Birthdate ____/____/____

Gender: Male Female Soc. Sec/Visa # _____

Home/Permanent Address

Street: _____

City or Town: _____

State or Country: _____

Current Radiation Exposure History

Have you ever been monitored for occupational radiation purposes in the current calendar year?

No Yes If yes, please provide the following information

Current year-to-date Dose Estimate (if known) _____ (rem)

Period of Employment _____ to _____

Name and Address of Previous Employer where monitored for radiation exposure:

Name of Employer _____

Street Address _____

City or Town _____

State or Country _____ Zip Code: _____

Privacy Notice

To comply with 10CFR835 we ask you to provide the above information. This information is covered by the Federal Privacy Act. We use it to determine your previous dose history, the proper dosimetry for you, and your address so that we can send dosimetry reports back to you. Furnishing all information requested on this form is voluntary; however, failure to provide such information may delay or even prevent completion of these actions. Information furnished on this form will be used by the EH&S Division and Line Management for collection of radiation exposure data and reports to DOE, as required in 10CFR835.

I agree to LBNL's collection and release of any radiation exposure information under the terms of the Privacy Act.

Signature _____

Date _____

Dosimetry Request Form

Side B

Note

If you are to be Escorted at all times when you are in an area requiring dosimetry, please check the appropriate box below and provide the name and employee number of your escort. If unescorted, please skip Access section.

Access

Escorted

Unescorted

Name of Escort _____

Escort Employee # _____

Requester Status

LBNL Employee # _____

LBNL Employee Participating Guest Visitor/Tour Member Contractor

How long will you be on site? < 90 days > 90 days

Work Location

Contact Information

Building/Room

Mail-Stop

Ex

LBNL Supervisor

Department

Please check all applicable boxes:

	Work Description:	Dosimeter*		Work Description:	Dosimeter*
<input type="checkbox"/>	X-Ray	802	<input type="checkbox"/>	Life Sciences – Labeling (³² P, ¹⁸ F, etc.)	802
<input type="checkbox"/>	Sealed Sources	802	<input type="checkbox"/>	EHS	802
<input type="checkbox"/>	88" Cyclotron	802/CR-39	<input type="checkbox"/>	Actinide	802/CR-39
<input type="checkbox"/>	Facilities	802	<input type="checkbox"/>	Other (neutron sources, X-Ray alignment, accelerator)	

* Quarterly exchange cycle unless otherwise noted

Is Extremity Dosimetry Required? YES ___ NO ___

DOSIMETRY OFFICE USE ONLY

CR-39

Yes

No

TLD Number: _____

Initials of Issuance Individual _____

Date of Issuance _____

Single Issue? Yes No

Cycle Date: _____

Distribution: Individual Distributor _____ Location: MS: _____

bldg/room

Database Entries: REMS Doctor Initials _____ Date: _____