UCONN HEALTH
RADIATION SAFETY

Office of Radiation Safety

Request for Dosimetry Assessment
Radiation Monitoring Badges

Please read, sign and mail or fax this completed form(s) to:
Radiation Safety, MC-1514 Fax: 3826

OFFICE USE

SERIES CODE ☐ Body ☐ Collar ☐ Finger
PARTICIPANT # MEDICAL ☐ RESEARCH ☐ OTHER ☐
HPS-N-1341 Deep Dose Assessment Protocol ☐

I am requesting: ☐ Permanent Dosimetry *(if you will be at UCH > 1 month)* ☐ Provisional Dosimetry ***(if needed for < 1 month or one time use)***

Last Name | First Name | M-I | M-F

Maiden Name | Date of Birth (Month Day Year) **D.O.B. is Required**

First 5 digits of your UCH ID if it is an old ID, or Last 5 digits of your UCH ID if it is a new ID.

Department: _____

Job Title: _____

Mail Code: _____ Phone: _____

1. Do you work with/handle RAM? ☐ Yes ☐ No

Are/Do you:

☐ Declared Pregnant ☐ Likely to Receive >10% Annual Limit ☐ Operate mobile X-Ray Where? _____

☐ Credentialed for Fluroscopy ☐ Approved by RSO for Other Reasons

NOTE : Fluoroscopy credentialed physicians are required to have body, collar and extremity dosimeters.

☐ Approved ☐ Not Approved

2. Authorized User (PI): (For Researchers Only) _____
3. Name of your immediate supervisor._____ Ext: _____

	Yes	No
4. Have you ever been issued dosimetry at UConn Health?	☐	☐
5. Have you had UCH Radiation Safety Training? ☐ *SABA* ☐ *Lecture* ☐ *Other* _____	☐	☐
6. Have you read the training instructions on how to properly wear, care for and return your dosimeter(s)?	☐	☐
7. Did you work with x-rays/radionuclides and were issued dosimetry at another facility other than UConn Health in the last 12 months? If so, please fill out below and sign "Request for Radiation Exposure History" form.	☐	☐

FACILITY:_____ FROM:_____ TO:_____

ADDRESS:_____ _____

CITY: STATE: ZIP CODE:

Sign and date this document to acknowledge that you have read, understand and agree with the conditions of the statement below.

Various regulatory agencies require individuals, who may be occupationally exposed to ionizing radiation, to wear personal radiation dosimetry. You will be issued dosimetry if we have determined that it is necessary for you to receive it. You must wear dosimetry at all times while working with radiation sources and/or radiation producing devices. They MUST be worn properly and returned to Radiation Safety by the second Friday of every month after receiving your new dosimetry. Failure to comply with badge policy requirements may result in progressive disciplinary action, up to and including withdrawal of privileges or termination of employment.

Email This Request to Radiation Safety

Signature: _____ Date: _____

UCONN HEALTH
RADIATION SAFETY

Office of Radiation Safety
Tel: 860-679-2250
Fax: 860-679-3826

To:

From: Kevin Higgins, BSME, MBA, PE
Radiation Safety Officer

Subject: Request for Radiation Exposure History

To Whom It May Concern:

The following individual was associated with your institution and has indicated he/she was occupationally exposed to radiation during that time. In order to comply with the provisions of 10CFR20, UConn Health requests this individual's radiation exposure history while at your facility. Please include results of bioassays that contributed to the total effective dose equivalent he/she may have received.

Last Name	First Name	From	To

Please forward exposure report to: ***UConn Health***
Office of Radiation Safety MC-1514
263 Farmington Avenue
Farmington, CT 06030 - 1514

Sincerely,

Kevin Higgins

BSME, MBA, PE Radiation Safety Officer

Authorization for the release of confidential radiation exposure records.

To whom it may concern:

I hereby authorize and request that all records of my radiation exposure history be released to the Radiation Safety Officer at UConn Health.

_____ _____
Signature Date