**SAINT LOUIS UNIVERSITY**

Office of Environmental Health & Safety
1402 South Grand Blvd., Caroline 305
St. Louis, MO 63104-1085
Office: 314-977-8609
Fax: 314-977-5560
http://oess.slu.edu

# Radiation Worker Dosimeter Application and Dose History Request Form

## Applicant Information

Full Name: _____
*Last* *First* *Middle Initial*

Date of Birth: _____ Social Security Number: _____
Sex: ☐ Male ☐ Female Work Phone: _____
E-mail Address: _____ Campus Address: _____
Position: _____ Department/Series Code: _____
Supervisor: _____ Dept. Badge Coordinator: _____

**I will work with the following forms of Ionizing Radiation:**

☐ Radionuclides ☐ Diagnostic X-Ray and C-Arm ☐ Dedicated Fluoroscopy (e.g. Interventional Radiology)

☐ Irradiators ☐ PET Radionuclides ☐ Other:_____

**Dosimeter Request:**

☐ Whole Body Dosimeter ☐ Collar & Waist Dosimeter (e.g. Interventional Radiology)

☐ Ring Dosimeter* ☐ Right ☐ Left ☐ Fetal Dosimeter^

**Ring dosimeters are required for those whose use of a high energy Beta, X, or Gamma emitter is ≥ 1 mCi/Experiment or use is ≥ 10 mCi/year.*
*^Declaration of pregnancy required*

## Previous Employer Information

*Occupational Exposure: Please complete the employer information for any institution where you are currently or have been previously issued a dosimeter to monitor your radiation exposure. Attach additional employer information to this application, if more than four previous employers apply.*

| | |
|---|---|
| Employer: | Employer: |
| Department: | Department: |
| Dates of Employment: | Dates of Employment: |
| Address: | Address: |
| City, State, Zip Code: | City, State, Zip Code: |

| | |
|---|---|
| Employer: | Employer: |
| Department: | Department: |
| Dates of Employment: | Dates of Employment: |
| Address: | Address: |
| City, State, Zip Code: | City, State, Zip Code: |

# SAINT LOUIS UNIVERSITY

Office of Environmental Health & Safety
1402 South Grand Blvd., Caroline 305
St. Louis, MO 63104-1085
Office: 314-977-8609
Fax: 314-977-5560
http://oess.slu.edu

| Applicant Name | | |
|---|---|---|
| Full Name: | | |
| *Last* | *First* | *Middle Initial* |
| Date of Birth: | | |

| Certification & Authorization | |
|---|---|
| *I hereby authorize the release of my radiation dose history to Saint Louis University, Radiation Safety Office, 1402 South Grand Boulevard, St. Louis, MO 63104* | |
| Signature: | Date: |

***NOTE***: ***This section is to be completed by previous employer***

| Employer information and Exposure Totals |
|---|
| Employer Name: |
| Address: |
| City/State/Zip: |

| **EXPOSURE TYPE** *(please complete all that apply)* | **MONITORING PERIOD** *(MM/DD/YYYY)* | | **YTD DOSE EQUIVALENT** *(mrem)* | **TOTAL ACCUMULATED DOSE EQUIVALENT** *(mrem)* |
|---|---|---|---|---|
| | DATE OF INCEPTION | DATE OF TERMINATION | | |
| Effective Dose Equivalent (EDE) | | | | |
| Deep Dose Equivalent (DDE) | | | | |
| Lens Dose Equivalent (LDE) | | | | |
| Shallow Dose Equivalent, Whole body (SDE, WB) | | | | |
| Shallow Dose Equivalent, Max. Extremity (SDE, ME) | | | | |
| Committed Effective Dose Equivalent (CEDE) | | | | |
| Committed Dose Equivalent, Max. Exposed Organ (CDE) | | | | |

| | |
|---|---|
| **PRINTED NAME:** | **DATE:** |
| **SIGNATURE:** | |
| **TITLE:** | **PHONE:** |