INDIANA UNIVERSITY
PUBLIC SAFETY
Environmental Health and Safety

REQUEST FOR PERSONNEL MONITORING SERVICE

This form must be filled out in its entirety or badges will not be ordered.

Last Name: _____ First: _____ MI: _____ Sex: M ☐ F ☐

Previous Name(s): _____ Date of Birth: _____ / _____ / _____ SSN #: XXX-XX-__ __ __ __

Hospital(s): _____ Department: _____

Bldg./Room: _____ Office Phone #: _____

Permit Holder or Badge Contact Person: _____ E-mail: _____

Submit this form and direct any questions to the Radiation Safety Office. Phone: 317-274-4797 Fax: 317-274-2332

Check the appropriate box:

☐I will be working with these radiation-producing/radiation containing machines. (Please check all that apply.)

☐Fixed X-Ray Unit	☐Fixed X-Ray Fluoroscopy	☐HDR
☐Portable X-Ray Unit	☐Portable X- Ray Fluoroscopy	☐Gamma Knife
☐CT	☐PET-CT	☐ ^{60}Co Teletherapy
☐CT Fluoroscopy	☐Accelerators	☐Other (Please List):_____

If you checked fluoroscopy, how much time per week? _____ hours
[If you are uncertain, ask your supervisor]

Will you be present in the exam room during any of these procedures? ☐ Yes ☐ No
If yes, please check below the protective devices that will be routinely worn:
☐ Lead Apron ☐ Lead Glasses ☐ Thyroid Collar ☐ Other _____

☐I will be working with unsealed radioactive material.
LIST RADIONUCLIDES AND MAXIMUM RADIOACTIVITY USED.
(You are also required to complete RSO Form A-3, Authorization to Use Radioactive Materials)

THIS SECTION MUST BE SIGNED BY ALL EMPLOYEES

I agree to wear all badges issued to me and to wear badges correctly each time I work with radioactive materials or machine-producing radiation. I also agree to wear all prescribed protective devices when I work with radioactive materials or machine-producing radiation. I understand that failure to follow these rules will result in losing my privilege to use radioactive materials or machine-producing radiation. If my work conditions change or there is a problem with my badges, I will notify Radiation Safety.

Signature:_____ Date:_____

THIS SECTION FOR FEMALE EMPLOYEES ONLY

All female employees who are occupationally exposed to radiation are required to review the U.S. Nuclear Regulatory Commission (NRC) *Regulatory Guide 8.13: Instruction Concerning Prenatal Exposure*. A copy of this regulatory guide is available on the NRC website or by contacting Radiation Safety. Specific questions regarding this topic should be directed to the Radiation Safety Office. By signing below, you acknowledge that you have received instruction contained in the NRC Regulatory Guide 8.13 concerning prenatal exposure, and I have been given an opportunity to ask questions.

Signature: _____ Date: _____

********CONTINUED ON NEXT PAGE********

FOR OFFICE USE ONLY

Date ordered: _____ Subaccount: _____ Dosimeter_____

Participant #: _____ Transferred _____ Reactivated_____

Temp. Badge #: _____

PAST EXPOSURE INQUIRY

In compliance with 10 CFR Part 20.2104 of the U.S. Nuclear Regulatory Commission's *Rules and Regulations*, our office may be required to obtain your history of accumulated dose due to occupational exposure. Therefore, if you have previously been monitored (i.e., worn a radiation badge) for radiation exposure at any time, including work at Indiana University and associated medical facilities, please provide *complete* information below. **If you know your past exposure(s) received at your previous employment(s), please provide that information to the side along with your signature.** Also, please read and sign the release statement at the bottom of this page.

Employer: _____

Address: _____

City/State/Zip: _____

Department: _____

Period Monitored: From_____/_____ To_____/_____

If you know your exposure from this employer

Exposure: _____ mrem

Signature: _____

Employer: _____

Address: _____

City/State/Zip: _____

Department: _____

Period Monitored: From_____/_____ To_____/_____

If you know your exposure from this employer

Exposure: _____ mrem

Signature: _____

Employer: _____

Address: _____

City/State/Zip: _____

Department: _____

Period Monitored: From_____/_____ To_____/_____

If you know your exposure from this employer

Exposure: _____ mrem

Signature: _____

RADIATION EXPOSURE HISTORY RELEASE STATEMENT

TO WHOM IT MAY CONCERN:

You are hereby granted permission to make available to the Indiana University Indianapolis Radiation Safety Office any and all information concerning my radiation exposure history. You are further authorized to include in your transmittal to said person any or all information regarding my radiation exposure history acquired by you from other persons, employers, or agencies if such records are in your possession.

_____ _____

Name (Type or Print legibly) Signature

XXX – XX - __ __ __ __

Social Security Number (last 4 digits) Date _____

PLEASE RETURN COMPLETED FORM TO: **Radiation Safety Office, Gatch Hall, Room 159**
1120 W. Michigan Street, Indianapolis, IN 46202
RADSAFE@iu.edu (P) 317-274-4797 (F) 317-274-2332