DIVISION OF RADIATION SAFETY
RADIATION DOSIMETER EVALUATION FORM

APPLICANT MUST BE REGISTERED AND HAVE AN DRS NUMBER BEFORE THIS FORM CAN BE SUBMITTED TO THE DIVISION OF RADIATION SAFETY .
To register with the Division of Radiation Safety, please either call 301-496-2255 or visit our website http://www.nih.gov/od/ors/ds/rsb/register.html

APPLICANT INFORMATION

Name: _____ DRS #: _____
Last First MI

NIH Mailing Address: _____ NIH ID #: _____ Phone: _____

Authorized User/Supervisor: _____ Phone: _____

Type of Appointment: ❑ Permanent (>4 Months) ❑ Temporary (<4 Months)

Are you a MINOR under the age of 18 years old? ❑ Yes ❑ No

Are you now being or have you been monitored for occupational radiation exposure within this current calendar year? ❑ Yes ❑ No

❑ I **do not** intend to use radioactive materials or other sources of radiation at the NIH.
(By indicating that you will not use sources of radiation now, your ability to be entered on an NIH 88-1 form could be delayed if the future use of a material or device is controlled by a Radiation Safety Protocol that requires a dosimeter evaluation.)

RADIONUCLIDE USAGE INFORMATION

WORKSHEET FOR RADIONUCLIDES
To the best of your ability please estimate the amounts, actual handling time (not duration of procedure) and frequency of use.

Procedure	Nuclide	Maximum Amount Used/Procedure (in mCi)	Time Radionuclide Handled/Procedure (in mins)	Frequency (procedures per year)	Totals MCAB USE ONLY

OTHER SOURCES OF RADIATION

Please list in the space below any other uses of ionizing radiation that you may encounter during normal work procedures
(i.e. PET Studies, Nuclear Medicine Patient Care, Fluoroscopy, Irradiator User, Cyclotron, X-ray)

_____

If my usage, type or quantity of radioactive materials changes significantly, I understand I am required to contact my Area Health Physicist to be reevaluated for dosimetry.

Signature: _____ **Date:** _____

After completing form please FAX to: 301-594-5338 or mail to DRS, Bldg 21, Rm. 139 MSC 6780
If you need assistance completing the form, contact your Area Health Physicist 301-496-5774

FOR MCAB USE ONLY

❑ Evaluated, **NO** Dosimetry Required

❑ Evaluated, Dosimetry Required

❑ Temporary Requested by HP, See Attached

DOSIMETRY ISSUED

Whole Body (P)
❑ **Zone 1 (Chest)**
❑ **Zone 13 (Collar)**
❑ **Zone 17 (Fetal)**
❑ **Other Zone**

Extremities (U)
❑ Zone 3 (right finger)
❑ Zone 4 (left finger)
❑ **Other** Zone

Ring Size
❑ Small (0)
❑ Medium (blank)
❑ Large (4)

Frequency
❑ Monthly (M)
❑ Bi-Monthly (G)
❑ Quarterly (N)

Badge Series

MCAB Initials

Date Evaluated