RADIATION WORKER REGISTRATION

Registrant: ____________________________________________
(Last Name) __________________________________________
(First Name ) __________________________________________
(M) ____________________________________________________

Sex:   _____ Male     _____ Female

Title/Position(s) ________________________________________

Department: ____________________________   Supervisor: ____________________________

Office Phone: ____________________________

University       Temple Hospital   Jeanes   Episcopal/Northeastern   Other     _________________________

Social Security Number:     TU ID:

Exposure:
Indicate your anticipated use of source of radiation at Temple University.

_____ Directly with unsealed radioactive materials (e.g., liquids)
   Radionuclide(s) Activity (mCi)

_____ Directly with sealed radioactive materials (e.g., brachytherapy sources)

_____ Directly with radioactive material in a device (e.g., irradiator teletherapy unit, HDR)
   Device:____________________  Building:________________________  Room:_______

_____ Directly with X-ray producing machine(s)

_____ Incidentally exposed to source of radiation (e.g., nurses for radiation therapy patients, anesthesiologist)

Describe source of exposure: __________________________________________________________

Other (describe): __________________________________________________________________

Total Radiation Exposure:
For the limited purpose of calculating your total radiation exposure please let us know if you are working with radiation and you are badged in another institution:

Institution/Company Name of RSO Phone number Address City State Zip Code

Training:
List any radiation safety training courses that you have attended. Please include the following.

Institution/Company Course Name/Topic Clock Hours Date

Experience:
List previous employment with exposure to radiation. If no previous experience indicate None. Please include the following.

Institution/Company Address City State Zip Code Dates

Radiation Exposure History:
Indicate your approximate radiation dose for the current calendar year in millirem.

Calendar year to date: __________________________ mrem

Have you been assigned a planned special exposure as defined by the NRC?   _____ No   _____ Yes

Signature: ____________________________ Date: ____________________________

This portion to be filled out by the authorized user/ x-ray machine supervisor.

I certify that I have given the above mentioned individual sufficient training in radiation safety so that they can work safely under my close supervision until they can take the next safety training class.

Signature: ____________________________ Date: ____________________________

Rev. 5/11/2015
Fax completed form to 215-707-1600 or e-mail to ehrs@temple.edu
Authorization to Release Radiation Exposure History

Name: _______________________________________.

Social Security Number: _______ - _______ - _______.

Alternate name for records(e.g., maiden name): ____________________________.

Authorization to release my radiation exposure records to Temple University is hereby granted. Photocopies of this release authorization are acceptable.

Signature: _________________________ Date: ____________.

RSD Use Only

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