

University of Texas Health Science Center  
Environmental Health & Safety Department  
Radiation Safety Division

**DOSIMETRY SERVICE ASSESSMENT AND EXPOSURE HISTORY FORM**

**Section 1: Participant Data**

As required in the *Texas Administrative Code*, Chapter 25, §289.202, the following information regarding your radiation exposure history this calendar year is necessary for assessment of dosimetry service. Please complete the following items, then sign and return this form to: *Radiation Safety Division, EH&S*

**Full Name:** \_\_\_\_\_  
Last
First
Middle

**Employee Identification Number:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Gender:** Female Male  
**Over the age of 18? Yes/No** \_\_\_\_\_ **Office phone number:** \_\_\_\_\_ **Location:** \_\_\_\_\_

List any other name(s) under which you have been monitored: \_\_\_\_\_

**Section 2: Circle the appropriate response:**

	Yes	No	UTHSCSA DOSIMETRY POLICY
(a) I will work with $^3\text{H}$ , $^{14}\text{C}$ , $^{35}\text{S}$ , $^{33}\text{P}$ , $^{125}\text{I}$ only:			If yes, no dosimeter required
(b) I will work with $^{32}\text{P}$ or $^{36}\text{Cl}$ >1 mCi per protocol:			If yes, ring dosimeter required
(c) I will work with $^{32}\text{P}$ or $^{36}\text{Cl}$ >10 mCi per protocol:			If yes, WB & ring dosimeter required
(d) I will work with $^{86}\text{Rb}$ , $^{22}\text{Na}$ , $^{51}\text{Cr}$ , $^{131}\text{I}$ >1 mCi per protocol:			If yes, dosimeter required
(e) I will work with X-ray fluoroscopy equipment:			If yes, dosimeter required
(f) I will work with PET imaging (RIC):			If yes, dosimeter required by RIC
(g) I will work for Environmental Health & Safety:			If yes, dosimeter required
(h) I am a voluntarily declared pregnant worker:			If yes, E/F dosimeter issued
(i) I will work with Dental or Diagnostic X-ray equipment			If yes, whole body dosimeter required
(j) I will work with Brachytherapy or LINAC Procedures			If yes, whole body dosimeter required
(k) I am not required, but would like a whole-body badge:			If yes, administratively badged
(l) I am not required, but would like an extremity badge:			If yes, administratively badged

Classification: Faculty    Laboratory Staff    Student    Resident    Other-Specify \_\_\_\_\_

With which Authorized User, Principal Investigator, or Department will you be working?

Authorized User / Department: \_\_\_\_\_ Dates: \_\_\_\_\_ through \_\_\_\_\_

**Section 3: Previous employment(s) involving radiation exposure this calendar year**

Have you been occupationally exposed to radiation sources this calendar year at another institution?    Yes    No  
 Does any concurrent employment to UTHSCSA require exposure to radiation sources this calendar year?    Yes    No

Facility Name: \_\_\_\_\_ Facility Name: \_\_\_\_\_

Department: \_\_\_\_\_ Department: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

\_\_\_\_\_ Mailing Address: \_\_\_\_\_

\_\_\_\_\_ Mailing Address: \_\_\_\_\_

Dates: \_\_\_\_\_ through \_\_\_\_\_ Dates: \_\_\_\_\_ through \_\_\_\_\_

**Section 4: Signature**

I authorize the release of my radiation exposure history to the University of Texas Health Science Center San Antonio and will notify Environmental Health & Safety in the event of changes to the above information.

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature \_\_\_\_\_ Permanent Address: \_\_\_\_\_

\_\_\_\_\_

*Return the completed form to: Radiation Safety Division, Environmental Health & Safety, Room 1.343T Dental School*