Radiation Worker Registration

Name: _______________ ______ _____________________ Title/Position: __________________________
First MI Last

DU ID Number: ______________________ Birth date: _____/_____/______ Gender: ❑ M ❑ F

Department: ____________________________________ Supervisor: ____________________________

Location (e.g., DUCOM, Hahnemann Hospital): ______________________ Building: _______________ Room: _______

Exposure

Indicate your anticipated use of sources of radiation:

❑ Directly with unsealed sources of radioactive material (e.g., liquids)

Radionuclide					
Activity (mCi)					

❑ Directly with sealed sources of radioactive material (e.g., brachytherapy sources)

❑ Directly with radioactive material in a device (e.g., blood irradiator) Device: ____________________

❑ Directly with x-ray producing machines. Unit Type: ______________________________________

❑ Incidentally exposed to sources of radiation (e.g., nurses caring for therapy patients, anesthesiologists)

Describe source of exposure: ____

❑ Other (describe): ____

Training

List any radiation safety training courses that you have attended.

Institution/Company | Course Name / Topic | Clock Hours | Approximate Date

Certifications

List any applicable certifications which demonstrate competency using radioactive material/radiation (e.g., CNMT, RTT)

Certification | Certifying body | Date

Experience

List all previous employment with exposure to radiation. If no previous experience, indicate "NONE."

Institution / Company | City | State | Source(s) Used | Quantity (if applicable) | Dates

Radiation Exposure History

Indicate your approximate radiation dose in millirem for the current calendar year

Deep Dose (whole body)	Shallow Dose (skin)	Extremity	Eye	Committed Organ Dose Equivalent	Total Effective Dose Equivalent

Have you been assigned a planned special exposure as defined by the NRC? ❑ no ❑ yes

Signature: ______________________________ **Date:** ______________________

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Training Required
☐ Orientation Only ☐ Short Course ☐ Special In-service
Training Received
☐ Orientation ☐ Short Course ☐ Special In-service

Monitoring Assessment & Assignment							
☐ None ☐ Discretionary ☐ Required	☐ Monthly ☐ Bimonthly	☐ Body ☐ Collar ☐ Waist	☐ Ring ☐ Fetal ☐ Other:	Facility	Badge Series	Participant No	Date Issued

Initial Badge Assignment				
Date issued:	☐ Monthly ☐ Bimonthly	Badge No. Badge No.	Type Type	Binary No. Binary No.

Authorization to Release Radiation Exposure History
to
Drexel University

Name: ______________________________

Social Security No.: ________-_____-_________

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

Authorization to release my radiation exposure records to Drexel University/Tenet University Hospitals is hereby granted. Photocopies of this release authorization are acceptable.

Signature: ___________________________ Date: ________________________

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Institution	Request Date	Follow-up 1	Follow-up 2	Received