SAINT LOUIS UNIVERSITY

Office of Environmental Health & Safety
1402 South Grand Blvd., Caroline 305
St. Louis, MO 63104-1085
Office: 314-977-6894 (Lance Peters)
Fax: 314-977-5560
http://oehs.slu.edu

Radiation Worker Dosimeter Application and Dose History Request Form

Applicant Information

Full Name: _____
Last *First* *Middle Initial*

Date of Birth: _____ Social Security Number: _____
Sex: ☐ Male ☐ Female Work Phone: _____
E-mail Address: _____ Campus Address: _____
Position: _____ Department/Series Code: _____
Supervisor: _____ Dept. Badge Coordinator: _____

I will work with the following forms of Ionizing Radiation:

☐ Radionuclides ☐ Diagnostic X-Ray and C-Arm ☐ Dedicated Fluoroscopy (e.g. Interventional Radiology)

☐ Irradiators ☐ PET Radionuclides ☐ Other:_____

Dosimeter Request:

☐ Whole Body Dosimeter ☐ Collar & Waist Dosimeter (e.g. Interventional Radiology)

☐ Ring Dosimeter* ☐ Right ☐ Left ☐ Fetal Dosimeter^

**Ring dosimeters are required for those whose use of a high energy Beta, X, or Gamma emitter is ≥ 1 mCi/Experiment or use is ≥ 10 mCi/year.*
^Declaration of pregnancy required

Previous Employer Information

Occupational Exposure: Please complete the employer information for any institution where you are currently or have been previously issued a dosimeter to monitor your radiation exposure. Attach additional employer information to this application, if more than four previous employers apply.

Employer:	Employer:
Department:	Department:
Dates of Employment:	Dates of Employment:
Address:	Address:
City, State, Zip Code:	City, State, Zip Code:

Employer:	Employer:
Department:	Department:
Dates of Employment:	Dates of Employment:
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Applicant Name			
Full Name:			
	Last	*First*	*Middle Initial*
Date of Birth:			

Certification & Authorization	
I hereby authorize the release of my radiation dose history to Saint Louis University, Radiation Safety Office, 1402 South Grand Boulevard, St. Louis, MO 63104	
Signature:	Date:

NOTE: ***This section is to be completed by previous employer***

Employer information and Exposure Totals
Employer Name:
Address:
City/State/Zip:

EXPOSURE TYPE *(please complete all that apply)*	**MONITORING PERIOD** *(MM/DD/YYYY)*		**YTD DOSE EQUIVALENT** *(mrem)*	**TOTAL ACCUMULATED DOSE EQUIVALENT** *(mrem)*
	DATE OF INCEPTION	DATE OF TERMINATION		
Effective Dose Equivalent (EDE)				
Deep Dose Equivalent (DDE)				
Lens Dose Equivalent (LDE)				
Shallow Dose Equivalent, Whole body (SDE, WB)				
Shallow Dose Equivalent, Max. Extremity (SDE, ME)				
Committed Effective Dose Equivalent (CEDE)				
Committed Dose Equivalent, Max. Exposed Organ (CDE)				

PRINTED NAME:	**DATE:**
SIGNATURE:	
TITLE:	**PHONE:**

Modified 8/23/2022