RS-03
Revised on 10/2015

Series: _____
Part. Number: _____
Account #: _____

University of Texas Physicians

UT PHYSICIANS DOSIMETRY SERVICE REQUEST 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.[1] **Please complete the following items, then sign and return this form to: *Radiation Safety Program, CYF G102*.**

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

Date of Birth: _____ **Gender:** Female _____ Male _____

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

[1]The University of Texas Health Science Center at Houston (UTHSC-H) is requesting this information, which will be shared with a third party dosimetry vendor, for the sole purpose of radiation dosimetry services. Social Security Number (SSN) is no longer requested for these services.

Section 2: Circle the appropriate response

				UTP DOSIMETRY POLICY
(a)	I will be performing medical x-rays.	Yes	No	If yes, dosimeter required.
(b)	I will be performing dental x-rays or bone densitometry.	Yes	No	If yes, dosimeter offered, but not required.
(c)	I will work with x-ray fluoroscopy equipment.	Yes	No	If yes, dosimeter required.
(d)	I will work with medical uses of radioactive material.	Yes	No	If yes, dosimeter may be required
(e)	I am a voluntarily declared pregnant worker.	Yes	No	If yes, dosimeter offered, but not required.
(f)	I am not required, but would like a whole-body badge.	Yes	No	If yes, administratively badged.
(g)	I am not required, but would like an extremity badge.	Yes	No	If yes, administratively badged.

Classification: Physician Faculty Staff (Employee) Student Resident Other, specify: _____
In which department and at which location(s) will you be working? **Department:**_____
Location(s): _____ **Starting Date:** _____

Section 3: Previous employment involving radiation exposure this calendar year

Have you been occupationally exposed to radiation sources this calendar year at another institution? Yes No
Does any other current employment require exposure to radiation sources this calendar year? Yes No
If you circled yes, please fill out the section(s) below.

Facility Name:_____

Department:_____

Mailing Address:_____

_____

_____

Dates: _____through_____

Facility Name: _____

Department: _____

Mailing Address: _____

_____

_____

Dates: _____through_____

Section 4: Signature

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

Applicant Signature: _____ Date: _____

Return the completed form to: ***Radiation Safety Program, UTHSC-H EH&S, 6431 Fannin St, CYF G102, Houston TX 77030***
Fax # 713-500-5841