



DOSIMETRY DAMAGED/INADVERTANT EXPOSURE FORM

(Please type or print)

Name: _____
(Last) (First) (Middle)

Social Security Number: _____

Date of Birth: ____/____/____

Institution: _____

Department: _____

Name of Immediate Supervisor: _____

Campus Telephone Number: _____

Period for which badge was worn (date on badge): _____

Badge Type: (Circle one) CL (Collar) TR (Trunk or Under Apron)
FN (Ring – Right or Left if applicable)
FS (Fetal Monitor)

Description of circumstances leading to damage or inadvertent exposure:

I do/do not request a replacement badge. I understand that I may be charged \$10.00 to cover the administrative cost for replacement.

Employee Signature/ Date

Immediate Supervisor Signature/ Date

For Radiation Safety Office Use Only:
Date Form Received: _____
Replacement badge number: _____
RSO Staff: _____

Return this form to:
Radiation Safety
714 W. Lombard St.
Baltimore, MD 21201
or fax to: **410-706-8212**