Dosimeter Request Form

Principal Investigator: Department:

First Name: Middle Name: Last Name:

Email address: Work Phone: Fax Phone:

Date of Birth MM/DD/Year: Sex: Male ☐ Female ☐

Hire Date: Laboratory room No.

Is ring badge require: Yes ☐ No ☐ Ring Finger: Left ☐ Right ☐ Ring Size ________

Have you received any exposures from radioactive materials or X-rays at other institutions this year? If yes fill out an occupational exposure form. YES ☐ NO ☐