

**X-RAY/RADIATION PRODUCING DEVICE WORKER APPLICATION**

Please print clearly

Name (First, MI, Last) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Female / Male  
 University ID # \_\_\_\_\_ Social Security # (last 4 digits)xxx-xx-\_\_\_\_\_  
 ISU Telephone \_\_\_\_\_ E-mail Address \_\_\_\_\_  
 ISU Department \_\_\_\_\_ Principle Investigator \_\_\_\_\_

Have you been a radiation worker at any location other than Iowa State University? Yes No  
 (If yes, a release authorization must be completed and signed)

Iowa State University requests this information for the purpose of complying with the requirements of 10 CFR 20.2102 and 641-40.19(136C) of the Iowa Administrative Code regarding the maintenance of personal radiation exposure records. **Personal information is kept confidential.** Incomplete applications will delay approval.

**A. Radiation Safety Training Requirements**

<i>Required Course</i>	<i>Date Completed</i>
X-Ray Safety Fundamentals	

**B. X-ray/Radiation Producing Device Information - Attach additional description if needed**

1. Radiation Producing Device kVp \_\_\_\_\_ mA \_\_\_\_\_ seconds \_\_\_\_\_

2. Beam Time \_\_\_\_\_ How Often Used \_\_\_\_\_ Is this a cabinet system? Yes / No  
 Experiment / Assay (describe) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Radiation Producing Device kVp \_\_\_\_\_ mA \_\_\_\_\_ seconds \_\_\_\_\_

4. Beam Time \_\_\_\_\_ How Often Used \_\_\_\_\_ Is this a cabinet system? Yes / No  
 Experiment / Assay (describe) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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**Principal Investigator Request for Addition to Authorization**

I certify that the individual named above has completed the listed requirements to use radiation producing devices at Iowa State University. I request that an amendment be made to my Authorization to include them as approved personnel.

I understand that it is my responsibility to supervise the work conducted by this individual, to provide them with specific training on laboratory operating and safety procedures, and ensure that they abide by all University rules and policies concerning the possession and use of radiation producing devices as outlined in the Radiation Safety, X-ray Systems, and Laboratory Safety manuals.

To the best of my knowledge the above information is correct. I also understand that the information provided will be used to determine if the applicant qualifies as a dosimetry participant. I further acknowledge that if the applicant does not qualify as a dosimetry participant that they may still request a dosimeter and I agree to cover all costs of dosimeter maintenance.

Signed (Participant) \_\_\_\_\_ Date \_\_\_\_\_

Signed (Principal Investigator) \_\_\_\_\_ Date \_\_\_\_\_

**Return the completed form to:** Environmental Health and Safety, 2408 Wanda Daley Drive/ 3602

**For EH&S use only**

Training Course \_\_\_\_\_

Test Date \_\_\_\_\_ Test Score \_\_\_\_\_

Applicant issued dosimetry YES NO Dosimeter(s) \_\_\_\_\_

Participant Number \_\_\_\_\_ Series Code \_\_\_\_\_

Former Name (if changed) \_\_\_\_\_