



DOSIMETRY DAMAGED/INADVERTENT EXPOSURE FORM

(Please type or print)

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

Last 5 digits of 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 request a replacement badge / I do not request a replacement badge (circle one).

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