

Health Physics/Radiation Safety

DOSIMETRY REQUEST FORM (rev. 06/15/2026)

Please complete this form and email it to the Dosimetry Coordinator: Diana Garcia dianagar@stanford.edu

Date of Request:		Radiation Work Start Date:	
Wearer First Name:		Wearer Last Name:	
Wearer Employee Email:			
Is the wearer 18 or older? (If not, provide DOB)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Date of Birth:
Ring Size (if applicable):	Small <input type="checkbox"/>	Medium/Large <input type="checkbox"/>	X-Large <input type="checkbox"/>

***Briefly explain what radiation sources you will be exposed to during your work. Please specify if you will be exposed to neutron-sources.**

***Medical Fluoroscopy and Lead Apron Attestation:**

Check this box and sign below if the only source of occupational radiation that you will be exposed to is medical fluoroscopic equipment while wearing a lead apron:	<input type="checkbox"/>
Signature:	Print Name:

***Check one of the three boxes below** and sign for the option that applies to you.

I certify that I have no prior occupational radiation exposure history from any previous employers during the current calendar year (as of the date of request above):	<input type="checkbox"/>
Signature:	Print Name:

I have attached a signed statement from myself or from my previous employer(s) that discloses the amount of occupational radiation exposure that I have received during the current calendar year (as of the date of request above) from my previous employment. I consent to the release of my occupational radiation exposure history to Stanford Health Physics.	<input type="checkbox"/>
Signature:	Print Name:

I have received occupational radiation exposure from a previous employer(s) this calendar year (as of the date of request above), but records of these exposures are unavailable to me. I understand that my occupational dose limits for the year will be reduced by 1.25 rem for each quarter for which records are unavailable.	<input type="checkbox"/>
Signature:	Print Name:

***Dosimetry Account Information:**

Institution: (SHC, SCH, SU, VAPA)		Department or Lab:	
Supervisor Name:		Supervisor Signature:	