

CSM RADIATION USER INFORMATION (Please type or print legibly)

Last Name	First Name	Initial	CWID	SSN *	Gender
					M <input type="checkbox"/> F <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Birth Date	Department	Building/Room	Office Phone	Lab Phone	Email

Authorized User	User Category
	AU <input type="checkbox"/> ISU <input type="checkbox"/> DSU <input type="checkbox"/> RPES <input type="checkbox"/> RPEO <input type="checkbox"/> Ancillary <input type="checkbox"/>

Note: See tree on back page. AU = Authorized User; ISU = Independent Supervised User; DSU = Directly Supervised User; RPES = Radiation Producing Equipment Supervisor; RPEO = Radiation Equipment Producing Operator; Ancillary = non-user

Indicate Dosimetry Needs (Exposure Personnel Monitoring Device)

Whole Body <input type="checkbox"/> Y <input type="checkbox"/> N	Neutron Use <input type="checkbox"/> Y <input type="checkbox"/> N	Ring : <input type="checkbox"/> Left Hand <input type="checkbox"/> Right Hand	<input type="checkbox"/> small <input type="checkbox"/> medium <input type="checkbox"/> large
(RSO only) Participant #	Type	(RSO only) Participant #	Type

Note: If you previously had dosimetry, please complete and submit a "REQUEST FOR RADIATION EXPOSURE HISTORY AND/OR TRAINING VERIFICATION" form for each such institution or employer.

Indicate what radiation sources you will be working with

Radioactive Materials	Radiation Producing Machine
Radionuclides:	<input type="checkbox"/> Accelerator <input type="checkbox"/> X-ray <input type="checkbox"/> Other (specify)
Maximum activity: mCi	mA: kV or kVp
Form: <input type="checkbox"/> Solid <input type="checkbox"/> Liquid <input type="checkbox"/> Gas	

Training (Authorized User or Radiation Producing Equipment Supervisor must complete this section)

Type	Where	Year	Hours	Who	Subjects
<input type="checkbox"/> RAM <input type="checkbox"/> X-ray					
<input type="checkbox"/> RAM <input type="checkbox"/> X-ray					
<input type="checkbox"/> RAM <input type="checkbox"/> X-ray					
<input type="checkbox"/> RAM <input type="checkbox"/> X-ray					

Experience (Authorized User or Radiation Producing Equipment Supervisor must complete this section)

Type	Where	Year	Months	Max Activity mCi or max kV/mA	Nuclides or Machine Type
<input type="checkbox"/> RAM <input type="checkbox"/> X-ray					
<input type="checkbox"/> RAM <input type="checkbox"/> X-ray					
<input type="checkbox"/> RAM <input type="checkbox"/> X-ray					
<input type="checkbox"/> RAM <input type="checkbox"/> X-ray					

*Your Social Security Number will be used ONLY for identification purposes to track radiation dosimetry, training and other records maintained by the Radiation Safety Officer. These records are confidential and may not be viewed by anyone except for yourself and the EHS staff.

The above information is accurate and complete. I understand that I may communicate directly, in confidence and without prejudice with the Radiation Safety Officer, the Colorado Department of Public Health and Environment, Radiation Control Division or the U.S. Nuclear Regulatory Commission on any matter concerning radiation protection.

Signature: _____ **Date:** _____

Authorized User's Signature: _____ **Date:** _____