

## VOLUNTARY DECLARATION OF PREGANANCY

Name \_\_\_\_\_

Title \_\_\_\_\_

Department \_\_\_\_\_

Stony Brook ID# \_\_\_\_\_

Account Name/Number \_\_\_\_\_

Approximate date of conception \_\_\_\_/\_\_\_\_/20\_\_\_\_

Approximate due date \_\_\_\_/\_\_\_\_/20\_\_\_\_

I am voluntarily declaring that I am pregnant. I understand that in addition to routine monitoring devices (if assigned), I will be required to wear a fetal dosimeter at all times while working at Stony Brook University Hospital and/or University. This monitor will be worn at the waist and at the waist under a protective apron if worn. I agree to return my dosimeter promptly during the designated exchange period. I intend to follow all radiation protection instructions given to me by Radiation Safety staff to ensure that my dose to the embryo/fetus does not exceed 50mRem a month and 500mRem for the entire pregnancy.

Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/20\_\_\_\_

I received copies of the following documents as part of an educational radiation safety counseling session. Initial the following to confirm receipt.

\_\_\_\_\_ Nuclear Regulatory Commission's Regulation Guide 8.13

\_\_\_\_\_ New York State 10 NYCRR 16, excerpts and link to document.

Radiation Safety Staff \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/20\_\_\_\_