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In accordance with 10 NYCRR 16.6(1) I am giving my permission to provide Stony Brook University/Hospital with the following information

* My occupational radiation dose received during this year.
* My lifetime cumulative occupational radiation dose.

You will need the following information to retrieve these records

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

ID number/SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I was employed from approximately \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

Thank you,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please forward the dose records to radiation safety via email to [**michelle.kehoe@stonybrook.edu**](mailto:michelle.kehoe@stonybrook.edu)or mail them to the address below:

**Stony Brook University**

**Environmental Health and Safety**

**Radiation Safety, M Kehoe**

**110 Suffolk Hall**

**Stony Brook, NY 11794-6200**

If you have any questions or concerns please contact me at (631) 402-2175.

Thank you,



Michelle Kehoe, RSO



