Stony Brook University
Environmental Health & Safety

Radiation Exposure History

Section A: Employee Information

Name:			Srony Brook ID:
Department:			Date of Birth:
Building:		Official Title:	
Room:	Zip:	Sex: M F	Phone No:

Section B: Radiation History

Have you ever worked in a radiation area? Yes No

Did you wear a monitoring device? Yes No

Previous Employer/Affiliation COMPLETE ADDRESS	Dates of Radiation Work (mo/yr - mo/yr)	Dosimeter Worn (Check if Yes))

I certify that the above information is correct and complete to the best of my knowledge.

Signature

Date

Section C: Authorization

I hereby authorize the release of my prior radiation history records to the Radiation Safety Officer, Stony Brook University, Stony Brook, NY 11794-6200.

Signature

Date

NOTE: Make extra copies if required for additional personnel