UNIVERSITY of MARYLAND
BALTIMORE

DOSIMETRY DAMAGED/INADVERTENT EXPOSURE FORM

(Please type or print)

Name: _____ _____ _____
(Last) (First) (Middle)

Last 5 digits of Social Security Number: _____

Date of Birth: _____/_____/_____

Institution: _____

Department: _____

Name of Immediate Supervisor: _____

Campus Telephone Number: _____

Period for which badge was worn (date on badge):_____

Badge Type: (Circle one) CL (Collar) TR (Trunk or Under Apron)
FN (Ring – Right or Left if applicable)
FS (Fetal Monitor)

Description of circumstances leading to damage or inadvertent exposure:

_____
_____
_____
_____
_____

I do request a replacement badge / I do not request a replacement badge (circle one).

_____ _____
Employee Signature/ Date Immediate Supervisor Signature/ Date

For Radiation Safety Office Use Only:
Date Form Received: _____
Replacement badge number: _____
RSO Staff: _____

Return this form to:
Radiation Safety
714 W. Lombard St.
Baltimore, MD 21201
or fax to: *410-706-8212*