

RADIATION WORKER LOST BADGE NOTICE REPORT

NAME:

Last _____ First _____ Middle _____

SSN _____

Birth date: ____/____/____

Authorized User: _____

Approximate Date of Loss: ____/____/____

Badge Type: Whole Body Ring/Extremity Fetal

Wear Period: Start _____ End _____

Replacement Requested: Yes No

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**Office Use:**

Part # \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_      Series Code \_\_\_\_ \_\_\_\_ \_\_\_\_

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I estimate the dose received during the lost wear date were

[] less than [] equal to [] greater than the normal dose

exposures I would normally receive.

Signature _____ Date _____

Figure 9
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