

**Case Western Reserve University (CASE)
Department of Environmental Health & Safety (EHS)
Radiation Safety Office (RSOF)**

RADIATION WORKER LOST BADGE NOTICE REPORT

Name: Last _____ First _____ Middle _____
Employee/ Student ID #: _____
Date of Birth: _____
Authorized User: _____
Department: _____
Location (Building/ Room): _____
Approximate Date of Loss: _____
Badge Type (circle): Whole Body Ring/ Extremity Fetal
Wear Period: Start _____ End _____
Replacement Requested: Yes No

Office Use:

Part# _____ **Series Code** _____

I estimate the dose received during the lost wear period was
___ less than ___ equal to ___ greater than
the normal dose exposures I would normally receive.

Signature _____ Date _____

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