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 _____