APPENDIX 2

FORMS

Suggested Format for New Proposals to Use Radioactive Material
to Radiation Control Committee

In order to achieve uniformity and to cover the pertinent items required by the Radiation Control Committee, the following outline should be followed as closely as possible in order to save time in getting your proposal approved by the Radiation Control Committee:

Date: _____

TO: Radiation Control Committee
Attention: Susan E. Stanford
Radiation Control Officer
Box 118340

FROM: Principal Investigator, (Signature required)
Department
Name of other users (technicians, students)

SUBJECT: Proposal to Use _____

Items that should be covered:

1. Brief description of the project.

2. Amount and chemical/physical form of radioactive material to be used.
3. Proposed use locations.
4. Proposed dates that this project will be carried out.
5. Protective clothing to be worn.
6. Whether or not work will be done in a hood.
7. Precautions to be taken to: (1) prevent the spread of contamination from unsealed sources, and (2) prevent external radiation exposure from penetrating radiation (x and gamma rays) by using proper shielding devices.
8. Radiation detection equipment that will be used for laboratory and personnel monitoring and frequency of use.
9. Disposal of radioactive waste.

Attach to proposal:

1. Statement of Training forms (RC-1) shall be attached for all individuals involved in the study. (Appendix B)

2. Proposal Summary Sheet (Appendix B)

SUMMARY SHEET
PROPOSAL TO USE RADIOACTIVE MATERIAL

1. Title of Proposal: _____

   _____

2. Radioactive material users:

Name	Position	UF Approved User	Relation to Project

3. Proposed Project Starting Date: _____

4. Radionuclides to be used:

Radio-nuclide	Form	Half-life	Principal Radiation	Activity Inventory Amount	Activity Used Per Experiment	Activity Total Project

5. Where are radioactive materials to be used (include building and room)? _____

   _____

6. What physical facilities are available (i.e. fumehood)? _____

   _____

7. How will lab surveys be done? How often? What equipment?_____

   _____

8. Describe any problems associated with final disposal of radioactivity: _____

   _____

Renewal of Radioactive Material Use Authorization

Proposal Title: _____

_____

Description of Project: _____

_____

Participants in Project:

Name	Position	Radioactive Material User Yes	No
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Radionuclides to be used:

Radionuclides	Chemical Form(s)	Inventory Amount (mCi)	Activity per Experiment	Activity per Year (mCi)

Locations (buildings/rooms) where radioactive materials are used and stored: _____

_____

_____

Physical facilities and equipment	Yes	No	Location
Fumehood	☐	☐	
Ultra centrifuge	☐	☐	
Centrifuge	☐	☐	
Cold room	☐	☐	
Other	☐	☐	

	Yes	No	Location	Make	Model
Liquid scintillation counter (LSC)	☐	☐			
LSC with external standard	☐	☐			
Gamma counter	☐	☐			
Laser system	☐	☐			
GC with ECD	☐	☐			
Portable radiation meter	☐	☐			
x-ray equipment	☐	☐			
Other	☐	☐			

Describe any anticipated problems associated with radioactive waste disposal: _____

_____

_____

Will you be generating radioactive mixed waste? _____

_____ _____

Prinicpal Investigator (Signature) Date

APPLICATION FOR THE USE OF RADIOACTIVE MATERIALS IN HUMAN SUBJECTS TO THE HUMAN USE OF RADIOISOTOPES AND RADIATION COMMITTEE (HURRC)

1. **Project Title**:

2. **Principal Investigator**:
   Co-Investigator(s):

3. **State** in which physicians are **licensed** to practice medicine:
   (Note that a physician listed on the University of Florida radioactive materials license must be included.)

4. Information regarding the investigator's basic training and clinical experience with radioisotopes should be forwarded to the Secretary of the Human Use of Radioisotopes and Radiation Committee prior to or at the time a proposal is submitted. Forms for submitting this information (**Preceptor/Applicant, RC-1**) are available from the Secretary's office.

5. **Abstract**: *(can be obtained from IRB Protocol)*

6. **Specific Aims**: *(can be obtained from IRB Protocol)*

7. **Background and Significance**: *(can be obtained from IRB Protocol*

8. **Research Plan**:

   Patient Eligibility:

   A. Inclusion Criteria

      1. Describe subjects to whom the isotope is to be administered as to number, age, sex and approximate weight.

      2. A brief comment as to the disease process with attendant life and health expectancy is warranted.

   B. Exclusion Criteria

      1. Can the data needed be obtained without using radioisotopes? If so, why are radioisotopes to be used?

   Study Design:

   A. Radioisotope Characteristics:

      1. Radioisotope(s) to be used

      2. Type and energy of radiation(s) emitted

      3. Physical half-life (lives)

      4. Biological half-life (lives)

      5. Target organ(s)

      6. Critical organ(s)

B. Clinical or Laboratory Procedures:

1. Dosage to be used; to be repeated?

2. Rationale for the dosage.

3. The proposal should be supported by citation of previous animal and/or human studies which have established the assimilation, distribution, selective localization, and excretion of the radioisotope (or its derivatives) sufficiently well to permit extrapolation to man for dosage purposes.

4. Mode(s) of excretion and per cent by each route.

5. Calculated radiation absorbed dose (in rad and Gray) to target organ, active blood-forming organs, lens of the eye, gonads, and to other critical organs over the entire period of the study and calculate an effective dose (in mrem) to the whole body. Show calculations.

6. Method by which radiation absorbed dose was calculated (i.e. MIRD, ICRP).

7. Expected duration of the study.

(Assistance in acquiring the correct information for sections A. and B. can be obtained from Dr. Shailendra Shukla at 376-1611, extension 6059, Kathleen Thomas at 376-1611, extension 6776 or Dr. Margaret Couch at 392-4700 extension 5569 for Nuclear Medicine procedures or Dr. Robert Zlotecki at 395-5723 for Radiation Oncology procedures.)

C. How will the radioisotope be assayed prior to each dosage?

D. How will the dose to the patient be monitored during the investigation? Is bioassay required? (Include information and calculations used).

E. Describe how personnel responsible for patient care will be trained in the hazards and precautions of the management of radioactive patients.

F. In what manner will radioactive waste produced by the patients be disposed of?

G. Information shall be provided to demonstrate that the amount of material to be administered shall be known not to cause any clinically detectable pharmacological effect in human beings. The pharmacologic dose calculations shall be based on data from published literature or from other valid human studies and should include:

1. active ingredients.

2. maximum amount administered per subject.

H. Information shall be provided to demonstrate that the proposed material to be administered:

1. meets appropriate chemical, pharmaceutical, radiochemical and radionuclidic standards of identity, strength, quality and purity.

2. is of a uniform and reproducible quality.

3. is sterile and pyrogen-free if radioactive material is for parenteral use.

4. is approved for use in humans by the FDA, i.e. not a "new drug".

(Assistance in acquiring the correct information for sections G. and H. can be obtained from Dr. Margaret Couch at 392-4700 extension 5569.)

I. Describe how adverse reactions will be reported.

J. A copy of the proposed radioactive drug label must be attached to this application.

9. **Potential Health Risks**:

Refer to the following for the appropriate risk statement. This statement must be included ***verbatim*** in the IRB Informed Consent Form, section 6, "Potential Health Risks or Discomforts".

APPLICATION FOR THE USE OF RADIATION IN HUMAN SUBJECTS

TO THE HUMAN USE OF RADIOISOTOPES AND RADIATION COMMITTEE (HURRC)

1. **Project Title**:

2. **Principal Investigator**:
   Co-Investigator(s):

3. **State** in which physicians are **licensed** to practice medicine:
   (Note that a physician approved by the Credentialing Committee for the use of x-ray machines must be included.)

4. Information regarding the investigator's basic training and clinical experience with radiation machines should be forwarded to the Secretary of the Human Use of Radioisotopes and Radiation Committee prior to or at the time a proposal is submitted. Forms for submitting this information (**RC-1X**) are available from the Secretary's office.

5. **Abstract**: *(can be obtained from IRB Protocol)*

6. **Specific Aims**: *(can be obtained from IRB Protocol)*

7. **Background and Significance**: *(can be obtained from IRB Protocol)*

8. **Research Plan**:

   Patient Eligibility:

   A. Inclusion Criteria

      1. Describe subjects to whom the radiation is to be delivered as to number, age, sex and approximate weight.

      2. A brief comment as to the disease process with attendant life and health expectancy is warranted.

   B. Exclusion Criteria

      1. Can the data needed be obtained without using radiation studies? If so, why are radiation studies being used?

   Study Design:

   A. Clinical Procedures:

      1. Type of radiation exam, i.e. if *Diagnostic* state type of Radiographic, Fluoroscopic, CT, or Mammography exam or type of *Radiation Oncology* procedure.

      2. Is this an exam that will be performed just once or repeated? If repeated, how many total exams for the duration of the study?

      3. Rationale for the exam.

4. The proposal should be supported by citation of previous studies which have established the assimilation and distribution of the radiation (or its derivatives) sufficiently well for dosage purposes.

5. For Diagnostic procedures, calculate the effective dose (in mrem) to the whole body for each exam and calculate a cumulative dose if multiple exams are proposed for the entire period of the study. Note if contrast media will be used and describe.

6. For Radiation Oncology procedures, state the therapeutic dose level.

7. Expected duration of the study.

(Assistance in acquiring the correct information for section A. can be obtained from Dr. Manuel Arreola at 395-4558 or Dr. Libby Brateman at 395-0291 for Diagnostic procedures or Dr. Robert Zlotecki at 395-5723 for Radiation Oncology procedures.)

9. **Potential Health Risks**:

Refer to the following for the appropriate risk statement. This statement must be included ***verbatim*** in the IRB Informed Consent Form, section 6, "Potential Health Risks or Discomforts".

Risk Statements for Informed Consent Form

Assistance in acquiring the correct information for these risk statements can be obtained from Dr Manuel Arreola at 395-4558 or Dr. Libby Brateman at 395-0291 for Diagnostic procedures or Dr. Robert Zlotecki at 395-5723 for Radiation Oncology procedures.

A. Informed Consent Statement for Diagnostic (Radiography, Fluoroscopy, CT, or Mammography) Procedures

This research study involves exposure to radiation from x-rays. The amount of radiation you will receive from this procedure exposes a portion of your body to a higher level of radiation than the rest of your body. The risks from radiation to only part of your body are considered to be less than the risks from radiation to your whole body. The radiation exposure from this procedure is typically (insert effective dose calculated in A-5 from "Study Design") mrem. A comparable exposure is equivalent to (insert number of days) days of the amount of natural background radiation exposure people in the United States receive each year. The risk from radiation exposure of this magnitude is too small to be measured directly and is considered to be low when compared with other everyday risks. The investigator will provide you with a contact person if you would like more information about radiation exposure. This contact person is (insert contact name and phone number).

B. Informed Consent Statement for Radiation Oncology Procedures using Therapeutic Irradiation Dosages

This research study involves exposure to radiation from (insert type of procedure or procedures). The amount of radiation exposure you will receive from this procedure will be at therapeutic doses with the intent of (insert intent of procedure). As a part of this study, vital organs and normal tissues may receive significant radiation exposure. The potential early and late side effects and the risks of these side effects occurring are as follows (insert for all organ systems which will receive significant radiation exposure in this study a listing of the potential acute and late side effects and known risks of occurrence at the proposed radiation exposure levels). The investigator will provide you with a contact person if you would like more information about radiation exposure. This contact person is (insert contact name and phone number).

C. Informed Consent Statement for All Radiation Procedures involving Potentially Pregnant Participants

This study may be hazardous to an unborn child. Therefore, participants who are still menstruating and have not been surgically sterilized must have a negative pregnancy test prior to participating in this study (or studies). The results of the pregnancy test will be made available to the study participant prior to the initiation of this study.

UNIVERSITY OF FLORIDA
STATEMENT OF TRAINING AND EXPERIENCE

(*To be completed by ALL personnel who will be working with radioactive material at the University of Florida*)

NAME:_____ DEPARTMENT:_____ PHONE: _____

CLASSIFICATION (*Faculty, Technician, Student, etc.*):_____

RADIOACTIVE MATERIAL TO BE USED:_____ PRINCIPAL INVESTIGATOR:_____

RADIATION SAFETY TRAINING

SUBJECT	*WHERE TRAINED*	*DATES AND DURATION OF TRAINING*	*PRECEPTOR/ ON THE JOB (Circle Answer)*	*FORMAL COURSE (Circle Answer)*
A. *Principles and practices of radiation protection*			*Yes No*	*Yes No*
B. *Radioactivity Measurement, standardization, monitoring techniques, and instruments*			*Yes No*	*Yes No*
C. *Mathematics and calculations basic to use and measurement of radioactivity*			*Yes No*	*Yes No*
D. *Biological effects of radiation exposure*			*Yes No*	*Yes No*
E. *Transportation of radioactive material*			*Yes No*	*Yes No*
F. *Operating and Emergency procedures*			*Yes No*	*Yes No*

RADIOACTIVE MATERIAL HANDLING EXPERIENCE

RADIONUCLIDE USED	*MAXIMUM AMOUNT*	*WHERE EXPERIENCE WAS GAINED*	*DATES AND DURATION OF EXPERIENCE*	*TYPE OF USE*

Have radiation exposure records been maintained for you at another institution? Yes No

I have read and will abide by the University regulations as set forth in the RADIATION CONTROL GUIDE.

*SIGNATURE:*_____*DATE:*_____

If additional space is needed, use the back of this sheet. Keep a copy and return original to:
RADIATION CONTROL DEPARTMENT - 212 Nuclear Sciences Center - Box 118340

DOCUMENTATION OF TRAINING FORM:

NAME:_____ DEPARTMENT:_____ PHONE: _____

CLASSIFICATION (*Faculty, Technician, Student, etc.*):_____

RADIOACTIVE MATERIAL TO BE USED:_____ PRINCIPAL INVESTIGATOR:_____

Check appropriate response:

☐ **Option 1: Radiation Safety Training Provided by Principal Investigator.**

TYPE OF TRAINING	*WHERE TRAINED*	*DATES AND DURATION OF TRAINING*	*TRAINING PROVIDER*
A. *Principles and practices Of radiation protection*			
B. *Radioactivity Measurement, Standardization, monitoring Techniques, and instruments*			
C. *Mathematics and calculations Basic to use and measurement Of radioactivity*			
D. *Biological effects of radiation Exposure*			
E. *Transportation of radioactive Materials*			
F. *Operating and Emergency procedures*			

☐ **Option 2: Radiation Safety Training provided by Radiation Control Department.**

I have contacted the Radiation Control Office Secretary and have enrolled the above individual in the next available Radiation Safety Short Course.

☐ **Option 3: Radiation Safety Training provided by credit course.**

I will assure that the above individual will enroll in and attend the following credit course:

_____

PI Signature: Date: _____

Return original to the:

RADIATION CONTROL DEPARTMENT - 212 Nuclear Sciences Center
Box 118340

APPLICATION FOR THE NON-HUMAN USE OF RADIATION PRODUCING DEVICES

TO THE RADIATION CONTROL COMMITTEE

1. Principal Investigator: _____
   Department: _____
   Office Room Number: _____ Phone Number: _____
   Lab Technician: _____ Phone Number: _____

2: Authorized user(s): Job Title:

_____	_____
_____	_____
_____	_____
_____	_____

3. Information regarding the Principal Investigator and authorized user(s) basic training with the radiation producing device shall be forwarded to the Radiation Control Office at the time this proposal is submitted. Forms for submitting this information (RC-1X) are available from the Radiation Control Office, phone 392-7359.

4. Type of radiation producing device:

___a. Radioagraphic: max mA___ max kVp___

___b. Fluoroscopic: max mA___ max kVp___

___c. Cabinet

___d. Diffraction: max mA___ max kVp___

___e. Other (explain)

5. Use of radiation producing device:

___a. Veterinary medicine

___b. Research using animals

___c. Diffraction analysis

___d. Research other than above (explai

6. Location of device:

Bldg.: _____ Room(s)_____

7. Describe the procedures for which the device will be used. Submit any locally generated standard operating procedures and safety instructions and confirm that an operator's manual is available at the unit. If factory installed safety interlocks must be bypassed during any use of the equipment, submit justification for bypassing the interlock.

8. Describe the facility in which the device will be used. Include shielding design for radiographic and fluoroscopic units and type of enclosure or shielding design for diffraction units. State if warning sign/lights are installed in or outside the facility and any protective equipment such as lead aprons or portable shielding.

9. Briefly describe personnel monitoring available.

Return original to the: RADIATION CONTROL OFFICE
212 Nuclear Sciences Center / Box 118340

UNIVERSITY OF FLORIDA
RADIATION PRODUCING DEVICE OPERATOR
STATEMENT OF CERTIFICATION, TRAINING, AND EXPERIENCE

(To be completed by ALL personnel who will be working with x-ray machines at the University of Florida and Shands Hospital)

NAME:_____DEPARTMENT:_____

CLASSIFICATION *(Faculty, Technician, Student, etc.)*_____

SUPERVISOR:_____PHONE:_____

TYPE OF X-RAY MACHINE TO BE USED:

_____Medical - Fluoroscopic _____Dental
_____Medical - Radiographic _____Diffraction
_____Industrial _____Analytical
_____Veterinary _____X-Ray Irradiator
_____Other_____

CERTIFICATION/LICENSURE (State of Florida):

_____Basic X-ray Machine Operator _____Dental Hygienist
_____CRT-Radiographer _____Dental Radiographer
_____CRT-Computed Tomography _____CRT-Therapy
_____CRT-Nuclear Medicine _____Other_____

Certificate/License Number:_____
Expiration Date:_____

NON-CERTIFIED/LICENSED INDIVIDUALS MUST COMPLETE THE REMAINDER OF THE FORM

RADIATION SAFETY AND X-RAY MACHINE OPERATION TRAINING			
SUBJECT	LOCATION	DATES	HOURS
Principles and Operation of X-ray machines _____ Preceptor _____ Formal			
Biological Effects of Radiation Exposure _____ Preceptor _____ Formal			
Radiation Safety _____ Preceptor _____ Formal			

X-RAY MACHINE OPERATING EXPERIENCE			
TYPE OF MACHINE	LOCATION	DATES	USAGE

Have radiation exposure records been maintained for you at another institution? YES NO
SIGNATURE _____DATE _____
Return original to the: RADIATION CONTROL OFFICE, 212 Nuclear Sciences Center / Box 118340

DOCUMENTATION OF TRAINING FOR RADIATION PRODUCING DEVICE OPERATOR

NAME _____ DEPARTMENT _____

CLASSIFICATION (*Faculty, Technician, Student, etc.*) _____

TYPE OF X-RAY EQUIPMENT TO BE USED _____

PRINCIPAL INVESTIGATOR_____PHONE _____

Check appropriate response:

_____Option 1: Radiation Safety Training Provided by Principal Investigator.

TYPE OF TRAINING	*WHERE TRAINED*	*DATES AND DURATION OF TRAINING*	*TRAINING PROVIDER*
A. *Principles and practices of radiation protection*			
B. *Significance of the radiation warning and safety devices incorporated into the equipment*			
C. *Operating and Emergency procedures*			
D. *Biological effects of radiation exposure*			
E. *Practical experience with the x-ray equipment to be used*			

_____Option 2: Radiation Safety Training provided by Radiation Control Department.

I have contacted the Radiation Control Office and have scheduled an in-service for the above individual.

_____Option 3: Radiation Safety Training provided by outside service.

I will assure that the above individual will enroll in and attend the following course:

_____ _____

PI Signature Date

Return original to the:

RADIATION CONTROL DEPARTMENT - 212 Nuclear Sciences Center
Box 118340

APPLICATION FOR THE NON-HUMAN USE OF LASERS
TO THE RADIATION CONTROL COMMITTEE

1. Principal Investigator: _____

   Department: _____

   Office Room Number: _____ Phone Number: _____

   Lab Technician: _____ Phone Number: _____

2: Authorized user(s): Job Title:

   _____ _____

   _____ _____

   _____ _____

   _____ _____

3. Information regarding the Principal Investigator and authorized user(s) basic training with the laser shall be forwarded to the Radiation Control Office at the time this proposal is submitted. Forms for submitting this information (RC-1L) are available from the Radiation Control Office, phone 392-7359.

4. Inventory of Lasers: (use attached form)

5. Describe the procedures for which the laser will be used. Submit any locally generated standard operating procedures and safety instructions and confirm that an operator's manual is available at the unit. If factory installed safety interlocks must be bypassed during any use of the equipment, submit justification for bypassing the interlock.

8. Describe the facility in which the device will be used.

9. Briefly describe personnel safety equipment available.

Return original to the:

RADIATION CONTROL OFFICE
212 Nuclear Sciences Center / Box 118340

UNIVERSITY OF FLORIDA
LASER USER
STATEMENT OF TRAINING AND EXPERIENCE

(*To be completed by ALL personnel who will be working with Lasers at the University of Florida*)

NAME: _____ DEPARTMENT: _____ PHONE: _____

CLASSIFICATION (*Faculty, Technician, Student, etc.*): _____

PRINCIPAL INVESTIGATOR: _____

ALL INDIVIDUALS MUST COMPLETE THE REMAINDER OF THIS FORM

LASER SAFETY TRAINING

SUBJECT	*WHERE TRAINED*	*DATES AND DURATION OF TRAINING*	*PRECEPTOR/ ON THE JOB (Circle Answer)*	*FORMAL COURSE (Circle Answer)*
A. *Fundamentals of Laser Operation*			*Yes No*	*Yes No*
B. *Laser Classifications*			*Yes No*	*Yes No*
C. *Control Measures*			*Yes No*	*Yes No*
D. *Bioeffects of Laser Radiation Exposure*			*Yes No*	*Yes No*
E. *Non-Radiation Hazards Associated with Lasers*			*Yes No*	*Yes No*
F. *Investigator and User Responsibilities*			*Yes No*	*Yes No*

LASER USE EXPERIENCE

LASING MEDIUM	*LASER CLASS*	*MAX OUTPUT POWER*	*DATES AND DURATION OF EXPERIENCE*	*WHERE EXPERIENCE WAS GAINED*

*SIGNATURE:*____*DATE:*_____

If additional space is needed, use the back of this sheet. Keep a copy and return original to:
RADIATION CONTROL DEPARTMENT - 212 Nuclear Sciences Center - Box 118340

DOCUMENTATION OF TRAINING FOR LASER USER

NAME _____ DEPARTMENT _____

CLASSIFICATION (*Faculty, Technician, Student, etc.*) _____

TYPE OF LASER(S) TO BE USED _____

PRINCIPAL INVESTIGATOR_____PHONE_____

Check appropriate response:

_____**Option 1: Laser Safety Training Provided by Principal Investigator.**

TYPE OF TRAINING	*WHERE TRAINED*	*DATES AND DURATION O TRAINING*	*TRAINING PROVIDER*
A. *Fundamentals of Laser operations*			
B. *Laser Classifications*			
C. *Control measures*			
D. *Biological effects of laser radiation exposure*			
E. *Non-radiation hazards of lasers*			
F. *Operating and Emergency procedures*			

_____**Option 2: Laser Safety Training provided by Radiation Control Department.**

I have contacted the Radiation Control Office and have scheduled an in-service for the above individual.

_____**Option 3: Laser Safety Training provided by outside service.**

I will assure that the above individual will enroll in and attend the following course:

_____

PI Signature Date

Return original to the:

RADIATION CONTROL DEPARTMENT - 212 Nuclear Sciences Center
Box 118340

RADIOACTIVE MATERIAL PACKAGE RECEIPT FORM

RECEIVING DATA

Principal Investigator	Dept	
Facility	Building	Lab Room
Radionuclide	Activity (mCi)	
Date Received ____/____/____	Received By	
RC Number	PO Number	
Supplier		

RADIATION SURVEY DATA

Surface of Container	mR/hr
Packing Material	mR/hr

CONTAMINATION SURVEY DATA

Surface of Container	dpm/100 sqcm

RADIATION CONTROL OFFICE

Review Date ____/____/____	Approval

Complete form upon package receipt and return or FAX to:

University of Florida
Radiation Control and Radiological Services
PO Box 118340
212 Nuclear Sciences Center
Gainesville FL 32611
FAX 352 846-0489

RADIONUCLIDE UTILIZATION FORM

PRINCIPAL INVESTIGATOR: _____ ROOM NO: _____

RADIONUCLIDE: _____ CHEMICAL/PHYISICAL FORM: _____

INITIAL ACTIVITY RECEIVED (μCi or mCi): _____ DATE RECEIVED: _____

Trasferred from PI: _____ Transfer Approval Date: _____

(USE A SEPARATE FORM FOR EACH SHIPMENT OF EACH RADIONUCLIDE RECEIVED)

Date	Activity Removed μCi-mCi	Activity Remaining μCi-mCi	Use	Final Disposal	Users Initials

NOTE: When this particular shipment of radioactive material has been completely utilized, decayed or disposed, maintain this form in laboratory files for review by State and University Radiation Control inspectors.

University of Florida
Radiation Control and Radiological Services Department
Quarterly Radioactive Material Inventory

PI: _____ Date: _____
(signature)

Department: _____

Building: _____ Room: _____

Inventory Date: _____

Isotope	Present Inventory (mCi)	Location	Remarks
^{3}H			
^{14}C			
^{125}I			
^{32}P			
^{33}P			
^{35}S			
^{51}Cr			
^{45}Ca			
^{60}Co			
^{137}Cs			
^{65}Zn			
^{22}Na			
^{36}Cl			
^{63}Ni			
^{192}Ir			
^{90}Sr			

Equipment Containing Radioactive Material.

	Manufacturer	Location
Liquid Scintilation Counter		
Gamma Counter		
Portable Survey Meter		
Gas Chromatograph w/ECD		
Nuclear Guage		

☐ **NO RADIOACTIVE MATERIAL IN MY POSSESSION**

RETURN FORM TO:
Phyllis Kelley
Environmental Health and Safety
212 Nuclear Sciences Center
PO Box 118340

UNIVERSITY OF FLORIDA

Radiation Control & Radiological Services

Laboratory Personnel

Date: _____

Principal Investigator: _____

Department: _____

Building: _____ Room(s): _____

Radioactive Material User's Name *(Please Print)*	Position/Classification	Approved RC-1 on file
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

I attest to the fact that the above named individuals are properly trained to use radioactive materials.

_____ _____

Principal Investigator (signature) Date

Return Form To: **Phyllis Kelley**
Environmental Health and Safety
212 Nuclear Science Center
PO Box 118340

UNIVERSITY OF FLORIDA
On Campus Radioactive Material Transfer Record

PRIOR APPROVAL OF RADIATION CONTROL DEPARTMENT
REQUIRED BEFORE ANY TRANSFERS ARE INITIATED

_____ _____
Principal Investigator Transferring (Print) Signature

Department: _____ Phone: _____

Room Number: _____ Bldg:_____

Date Transferred: _____

_____ _____
Principal Investigator Receiving (Print) Signature

Department: _____ Phone: _____

Room Number: _____ Bldg: _____

Date Received: _____

License No.: _____

Approval:_____ Date:_____
Radiation Control

Radioactive Material Description				Is this a single transfer or part of a series of scheduled transfers? Explain below
Item No.	Radio-nuclide(s)	Physical Form	Activity	

UNIVERSITY OF FLORIDA

Radioactive Material Transfer Record

PRIOR APPROVAL OF RADIATION CONTROL DEPARTMENT REQUIRED BEFORE ANY TRANSFERS ARE INITIATED

SHIPPER: _____ _____
Principal Investigator Co-Worker

Department: _____ Ext: _____

Room Number: _____ Bldg: _____

Shipping Date: _____

License No: _____

Approved by: _____ Date: _____
Radiation Control Officer

RECEIVER: _____ _____
Principal Investigator Co-Worker

Department: _____ Ext: _____

Room Number: _____ Bldg: _____

Shipping Date: _____

License No: _____

Approved by: _____ Date: _____
Radiation Control Officer

Radioactive Materials Description

Item No.	Radio-Nuclide	Physical Form	Activity (mCi)	Radiation Levels	
				Surface	3 ft.

PERSONNEL MONITORING DEVICE APPLICATION

University of Florida
Division of Environmental Health & Safety
Department of Radiation Control & Radiological Services
P.O. Box 118340, 212 Nuclear Sciences Center, Gainesville, FL 32611
Telephone: (352) 392-7359 or (352) 392-8700
Fax: (352) 846-0489

THIS REQUEST IS TO:
- ☐ Reactivate an old badge
- ☐ Apply for a new badge

- ☐ whole body, collar
- ☐ whole body, waist
- ☐ whole body, fetal*
- ☐ extremity, rt hand
- ☐ extremity, lt hand
- ☐ extremity, rt wrist
- ☐ extremity, lt wrist

*A request for a fetal monitor must be accompanied by a copy of the letter to the employee's supervisor declaring pregnancy and approximate date of conception.

PRINT NAME: _____
(LAST, FIRST, MIDDLE INITIAL)

UFID: _____ - _____

DATE OF BIRTH: ____/____/____
mo day yr

SEX: ☐ MALE ☐ FEMALE

PRINCIPAL INVESTIGATOR/SUPERVISOR: _____

FILM BADGE COORDINATOR: _____

DEPARTMENT: _____

FACILITY: _____ BLDG _____ ROOM _____

MAILING ADDRESS: BOX _____ PHONE _____

DO YOU WORK WITH:
- ☐ radiation producing device (x-ray machine, accelerator, irradiator)
- ☐ radioactive material; list radionuclide(s) _____

If you directly work with radioactive material or radiation producing devices, a completed *Statement of Training and Experience* form must be attached for approval.

If you do not work with radioactive material or a radiation producing device, list the reason for this badge request:

_____

_____

(Based on this reason, the badge may/may not be issued at the discretion of the Radiation Control Officer.)

OFFICE USE ONLY	
RCO Approval	
Landauer #	Part ID#
Binary #	Series Code
	Date Issued

COMPLETE OTHER SIDE OF FORM

OCCUPATIONAL RADIATION EXPOSURE HISTORY IDENTIFICATION

Have you **EVER** received a personnel monitoring device or participated in a bioassay program somewhere other than UF/Shands HealthCare System and Clinics: ☐ YES ☐ NO

IF YES, COMPLETE THE FOLLOWING:

OCCUPATIONAL EXPOSURE--PREVIOUS HISTORY			
Previous employment involving occupational exposure--list name and address of employer	**Date of Employment** (From--To)	**Period of Exposure** (From--To)	Estimated Radiation Exposure (mrem)

Certification: I certify that the exposure history information listed above is correct and complete to the best of my knowledge. I authorize the release of my radiation exposure records to the University of Florida.

Employee Signature: _____ Name (Print): _____

UFID: _____-_____ Date: _____