ATOMIC ENERGY REGULATORY **AUTHORITY**

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All Communications should be addressed to: The Executive Director

APPLICATION FOR RADIATION MONITORING SERVICE

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| **1. INSTITUTION DETAILS** | | | | | | | | |
| **Institution:** |  | | | | | | | |
| **Address (Delivery):** |  | | | **Address (Billing):** | |  | | |
| **Location:** |  | | | **Location:** | |  | | |
| **Telephone No:** |  | **Fax No:** |  | **Telephone No:** |  | | **Fax No:** |  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **2. Legal Person (Head of Institution)** | | | | | | | |
| **First and Last Name:** |  | | | **Designation:** |  | | |
| **Telephone No:** |  | **Mobile No:** |  | | | **E-mail Address:** |  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **3. RADIATION SAFETY OFFICER** | | | | | | | |
| **First and Last Name:** |  | | | **Designation:** |  | | |
| **Telephone No:** |  | **Mobile No:** |  | | | **E-mail Address:** |  |

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| **4. TYPE OF MONITORING REQUIRED** | | | | | |
| Please tick the type of monitoring required: | Personnel – Whole body Monitoring (WM) | | \*Personnel – Extremity monitoring (EM) | \*Environmental / Workplace monitoring (WM) | |
| Quantities monitored *(for applicant’s information)* | Personal Dose equivalents to the body, Hp(10) [deep dose] and  Hp(0.07) [skin dose] | | Personal Dose equivalent to the extremities, Hp(0.07) | Ambient dose equivalent H\*(10) | |
| Please provide the number of monitoring  badges or dosimeters required: |  | |  |  | |
| Please provide the monitoring frequency | Monthly | Quarterly | Monthly | Monthly | Quarterly |

*\*Please note that NDL is not currently providing EM and WM*

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| --- | --- | --- |
| **5. DECLARATION BY THE LEGAL PERSON** | | |
| I, the undersigned, declare that the information given in this application is true and complete to the best of my knowledge. | | |
| **Name of Legal Person:** |  | **Position**: |
| **Signature of the Legal Person:** |  | **Date:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **6. For Office use:** | I acknowledge receipt of the application form and certify that the information provided is complete. | | |
| Name and Signature of Officer: |  | Date: |

**APPENDIX1: INDIVIDUAL RADIATION MONITORING SERVICE - WEARER REGISTRATION**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Surname** | **First Name** | **National ID or**  **Passport Number** | **Date of Birth (dd/mm/yyyy)** | **Gender (M / F)** | **Occupation** | **Date of Commencing Employment** | **Department/Section (e.g. Radiology, radiotherapy, etc)** |
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**APPENDIX 2: DETAILS OF THE RADIATION EQUIPMENT OR SOURCES**

*(Please fill the table applicable)*

2.1 Details of the X-ray Machine (s) that are currently used/or that you intend to use

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| X-Ray Unit Type | Manufacturer | Model Number | Serial number | Minimum Voltage (keV) | Maximum Voltage (keV) | \*Status of X-Ray Machine |
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\**Please state whether the machine is active, unfunctional or functional but stored*

**2.2 Details of the Radiation source (s) that are used/or you intend to use**

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| --- | --- | --- | --- | --- | --- |
| **Radiation Source/radionuclide** | **Activity** | **\*Use** | **IF THE SOURCE IS ENCLOSED IN A DEVICE** | | |
|  |  |  | Device manufacturer | Model | Serial number |
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\**Please state what the radiation source is being used for*