Please Print Clearly:  

Name: ___________________________________________  UNI/NYPH-ID: ____________________  

(LAST)  (FIRST)  

Date:_________________________  

Department:______________________________  Dept. Address: ________________________  

Check Affiliation:  □ CUMC  □ NYPH  □ NYSPI  □ Morningside  □ Nevis/Lamont  □ Lasker  

Occupation: □ Principal Investigator  □ Physician  □ Nurse/Tech  □ Student/Volunteer  □ Other  

Your Tel. No.:_____________________________  Date of Birth:_____/_____/_______  

Current E-mail Address:____________________  Gender: □ Male □ Female  

Supervisor or PI: ___________________________  Dept. Ext.: ____________________  

(FULL NAME)  

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Sources of radiation you will be working with:  (Please CHECK)  

□ X-Ray □ Fluoroscopy □ CT □ Radioactive Materials (RAM) □ Irradiators □ Other ________  

Are you a Physician initiating X-Rays during Fluoroscopy? □ Yes □ No  

*Mandatory RASCAL Online course is required for all Physicians working with Fluoroscopy*  
(https://www.rascal.columbia.edu/)  

Sources of radioactive materials you will be working with (specify): ___________________________  

Will you be working with 10 mCi or more of P32? □ Yes □ No  

Will you inject humans with radioactive isotopes? □ Yes □ No  

Have you ever worn a Personal Monitoring Dosimetry Badge at Columbia University, Columbia University Medical Center, Morningside, New York- Presbyterian Hospital, □ Yes □ No and/or New York State Psychiatric Institute?  

Have you worn a Personal Monitoring Dosimetry Badge with another institution? □ Yes □ No  

*If you answered YES, please complete and sign our Previous Exposure Release Form  
(http://ehs.columbia.edu/PreviousRadiationExposureReleaseForm.pdf)  

STATEMENT OF AGREEMENT  

This is to certify that I have attended a Radiation Safety Lecture for instruction in the techniques and hazards of working with radioactive materials and/or radiation producing devices or have completed a Rascal online post-test.  

Date: ___________________________  Signature: ___________________________________________  

□ Yes □ No
All employees attending this training must take the quiz below OR
Log on to RASCAL (www.rascal.columbia.edu) to complete their Radiation Safety Training Post-Test
and email the certificate to badges@columbia.edu

POST LECTURE QUIZ

True  False  (Please CHECK)

☐  ☐  1. There are potential health effects associated with excessive radiation exposure.

☐  ☐  2. Everyone is exposed to some level of naturally occurring radiation.

☐  ☐  3. Workers should always keep their exposure to radiation as low as reasonably achievable.

☐  ☐  4. Radioactive material is used in various departments or labs.

☐  ☐  5. Workers must wear their radiation dosimeters when on duty but they may not take their dosimeter out of the facility.

☐  ☐  6. Declared pregnant workers have special rules with regard to their exposure to radiation.

☐  ☐  7. Workers must wear disposable gloves when handling radioactive material.

☐  ☐  8. Workers may not eat or drink in areas where radioactive material is used.

☐  ☐  9. The telephone number for the Radiation Safety Office is (212) 305-0303.

☐  ☐  10. The Radiation Safety Officer is responsible for the safe use of radiation at Columbia University Medical Center and New York Presbyterian Hospital.

As an occupationally exposed individual, you are advised that:

• You have a right to request a report about your exposure to radiation.
• Your dosimeter must be worn only during work hours.
• Your dosimeter must not be taken to other places of employment.
• The dosimeter must be worn on the body or extremity as directed by the RSO.
• A lost dosimeter must be reported to Radiation Safety immediately.
• Damage to a dosimeter must be reported to Radiation Safety immediately.
• Your dosimeter must not be intentionally damaged, destroyed or exposed to high heat or humidity for extended periods of time.
• Your dosimeter must be returned at the end of the monitoring period.

(FOR OFFICE USE ONLY)

PERMANENT BADGE

ACCOUNT NUMBER: ___________________________  SERIES: ___________________________

PARTICIPANT NUMBER: ________________________  DATE ISSUED/MAILED: ________________

☐ Chest Badge (Pa)  ☐ Collar Badge (Pa)  ☐ Ring (U)  ☐ Fetal Badge

COMMENTS: __________________________________________________________________________

□ Entered in Landauer  □ Entered in SHED

Radiation Safety Form No. 1, Version Jan. 2014