

**University of Pennsylvania
Radiation Safety Evaluation for Pregnant Personnel**

Name: _____ SSN: _____

Licensee: _____ Work Phone: _____

Position (Physician, Technician, Post-Doc, etc.) _____

Occupational radiation exposure received as follows:

Medical X-ray Dental X-ray Veterinary X-ray

Other X-ray, specify: _____

Nuclear Medicine

Radionuclide: Specify nuclide(s), maximum amount handled, frequency

Date of conception _____

Date of delivery _____

I am voluntarily declaring that I am pregnant. I have received training on the dose limits to the embryo/fetus of a declared pregnant woman as specified by the Nuclear Regulatory Commission (10 CFR 20.1208). I have received information on biological risk and received suggestions for reducing exposure and have been given a copy of Reg. Guide 8.13 .

Signature

Date

RSO Staff Signature (after counseling)

Date

To be completed by Radiation Safety Office

Counseling date _____

by phone

in person

Persons present _____

Special precautions recommended:

External monitoring required: Y/N

Internal monitoring required: Y/N

Type monitoring provided _____

RSO Code _____

Final Check Off (RSO Staff Signature)
To be completed after reviewing final dose.

Date