

## OSL PERSONNEL MONITORING SERVICE APPLICATION FORM

### I. CUSTOMER INFORMATION

1. Name of Institution: \_\_\_\_\_
2. Address: \_\_\_\_\_ ☐ Private ☐ Gov't
3. PNRI/FDA License No. \_\_\_\_\_ Date Issued: \_\_\_\_\_
4. Radiation Safety Officer: \_\_\_\_\_
5. Contact No. / Fax.: \_\_\_\_\_ Email: \_\_\_\_\_
6. Purpose or Use of OSL (*please check*)

MEDICAL	INDUSTRIAL
<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> Industrial Irradiation
<input type="checkbox"/> Conventional Diagnostic Radiology	<input type="checkbox"/> Industrial Radiography
<input type="checkbox"/> Interventional Procedures (Cardiovascular)	<input type="checkbox"/> Radioisotope production or distribution
<input type="checkbox"/> Radiotherapy	<input type="checkbox"/> Industrial Gauges
<input type="checkbox"/> Dental Practice	<b>MISC.</b>
<input type="checkbox"/> Veterinary Medicine	<input type="checkbox"/> Educational Establishments
<input type="checkbox"/> Mammography	<input type="checkbox"/> Waste Spent Sources
<b>OTHERS (<i>please specify</i>)</b>	<input type="checkbox"/> Transport of Radiation Sources
	<input type="checkbox"/> Service Provider

7. For Medical X-ray and Industrial X-ray machine: (*please supply data for the equipment, attach additional sheets if necessary*)

Type/Brand: \_\_\_\_\_ Date Acquired: \_\_\_\_\_

No. of units: \_\_\_\_\_ Maximum kV: \_\_\_\_\_ Maximum mA: \_\_\_\_\_

8. Please indicate desired type of subscription: (*please check*)

☐ Mail ☐ w/Pouch ☐ Pickup

### II. TERMS & CONDITIONS

- a. In addition to the terms and conditions, the customer has read and agreed to the contents detailed in the Letter of Agreement (LOA) and to duly send 3 copies notarized LOA.
- b. The Dose Monitoring Reports shall be available within 40 working days upon receipt of the used OSL Dosimeters. The results shall only be released to the person who applied for the service or to any authorized representative.
- c. The Institute is implementing a CASH PAYMENT POLICY. Payments accepted may be in Cash, Postal Money Order, Company check or Managers check payable to the Philippine Nuclear Research Institute. The services being requested will be provided only upon presentation of the official receipt and completion of requirements.

*I have read and agreed with all the terms and conditions stated upon and other supplementary provisions regarding special conditions and/or agreement.*

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Received by

### III. PERSONNEL INFORMATION

☐ Check box if it is for additional OSL Dosimeter user

Name of Institution: \_\_\_\_\_ Customer Code (for existing subscribers): \_\_\_\_\_

Fill out the table COMPLETELY and LEGIBLY. You may use additional sheets if necessary.

FIRST NAME	MIDDLE NAME	LAST NAME	NAME EXTENSION	DATE OF BIRTH	SEX	OCCUPATION **	PREVIOUS WORK w/ RADIATION *** (when and where)

\* Please indicate a prefix G for GSIS No., P for Passport or S for SSS No.

\*\* Occupation (Dr., Engineer, Nurse, Rad. Tech., etc.)

\*\*\* Please indicate by appropriate letter.

a) Office work

b) Field work e.g. Nuclear medicine laboratory, research laboratory, etc.

c) Facility radiation area e.g. Industrial Gauges, Medical Radiography,  
Teletherapy, Brachytherapy.

\_\_\_\_\_  
Signature over Printed Name

\_\_\_\_\_  
Designation