

X-RAY APPLICATION

Division of Research Safety
 Radiation Safety
 radsafety@illinois.edu

101 S. Gregory St., Room
 106 Urbana, IL 61801-3070
 (217) 333-2755

PI/Responsible Person: _____

Department: _____

Office Address: _____

Phone: _____

Email Address: _____@illinois.edu

1. List all X-ray Personnel and their Net ID

NAME	NET ID	NAME	NET ID

2. Please submit a description of applicable experience and training in the use of radiation-generating equipment for each authorized user listed above. Include where the experience was obtained and the period of experience. (attach additional sheets if necessary)

3. Attach a description of each x-ray unit, including shielding, interlocks, warning devices, and other safety features. (page 3 can be used to complete this information)

4. List the portable radiation survey instrument that is present in the facility to monitor radiation fields: **If applicable not required for enclosed X-ray systems.**

5. Provide a brief description of the research that will be conducted under this permit:

Certification

I certify that the information stated herein is true and correct. This application is made under and in conformity with all applicable federal, state, and University regulations pursuant to the use of analytical x-ray equipment. I understand that all individuals working in the areas where radiation hazards may exist, will be informed of: the use of radiation-producing equipment; the health risks associated with radioactive materials; precautions to minimize exposure; the responsibility to promptly report any condition which may cause a violation of the regulations/license or unnecessary exposure to radiation. I further certify that radiation-producing equipment will not be transferred to another person or place inside or outside of the University without the prior consent of the Radiation Safety Section.

Signature of applicant: _____ Date: _____

For RSS use only

Approved by: _____ Date: _____

DESCRIPTION OF X-RAY PRODUCING EQUIPMENT USED UNDER PERMIT # _____

X-ray Unit No. _____

Generator Manufacturer/Model No.	
Generator Serial No.	
Generator Manufacture Date	
Tube Manufacturer/Model No. <i>If applicable, not required</i>	
Tube Serial No. <i>If applicable, not required</i>	
Maximum Tube kVp & mA	
X-ray Unit Location	
Shielding/Interlocks	
Warning Devices	
Unit Type (radiographic, mobile, CG, therapy fluoroscopic, dental, MDP, industrial)	

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