**UNIVERSITY of WATERLOO**

*Information Memo to X-Ray Workers*

<table>
<thead>
<tr>
<th>PART OF BODY IRRADIATED</th>
<th>EXPOSURE CONDITIONS AND COMMENTS</th>
<th>DOSE EQUIVALENTS AND ANNUAL LIMITS (millisieverts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 1</td>
<td>Column 2</td>
<td>Column 3 X-Ray Workers</td>
</tr>
<tr>
<td>Whole Body or Trunk of Body</td>
<td>Uniform irradiation</td>
<td>50</td>
</tr>
<tr>
<td>Partial or non-uniform irradiation of body</td>
<td>The limit applies to the EFFECTIVE DOSE EQUIVALENT</td>
<td>50</td>
</tr>
<tr>
<td>Lens of eye</td>
<td>Irradiated either alone or with other organs or tissues</td>
<td>150</td>
</tr>
<tr>
<td>Skin</td>
<td>The limit applies to the mean dose equivalent to the basal cell layer of the epidermis for any area of skin 1 square centimetre or more.</td>
<td>500</td>
</tr>
<tr>
<td>Individual organ or tissue other than lens of eye or skin</td>
<td>The limit on effective dose equivalent applies, with an overriding limit on the dose equivalent to the individual organ or tissue</td>
<td>500</td>
</tr>
</tbody>
</table>

An employer shall take every precaution reasonable in the circumstances to ensure that the mean dose equivalent received by the abdomen of a pregnant worker does not exceed five millisieverts during a pregnancy.

1. The undersigned worker has been instructed and demonstrated competence in the safe operation of the following X-Ray equipment.
2. The undersigned worker acknowledges classification as an X-Ray worker and is familiar with the dose equivalents that may be received by an X-Ray worker as shown above.

MODEL______________________     MANUFACTURE_______________________________

MODEL______________________     MANUFACTURE_______________________________

MODEL______________________     MANUFACTURE_______________________________

BUILDING____________    Rm._________    Dept._______________________

Worker__________________________    Date______________________

Supervisor___________________________    Date_______________________
WORKER REGISTRATION INFORMATION

This information will only be used to register you for dosimetry services supplied by Health Canada’s, National Dosimetry Service

Please Print

First Name ____________________________________________

Middle Name ____________________________________________

Last Name ____________________________________________

Sex

☐ F

☐ M

Social Insurance Number __ __ __ - __ __ __ - __ __ __

Date Of Birth (Month/Day/Year) _______/_________/________

Place Of Birth

City

Province/State

Country

Please complete and return to

Greg Friday
Safety Office
Commissary Building