UNIVERSITY OF CALIFORNIA RIVERSIDE
RADIATION WORKER LOST BADGE NOTICE REPORT

Name: Last_____________ First________________ Middle__________
Employee/ Student ID #: ______________________________________
Date of Birth: __________________
Primary Investigator ________________________________
Department: ________________________________________________
Location (Building/ Room): ____________
Approximate Date of Loss: ________________________________
Badge Type (circle): Whole Body  Ring/ Extremity  Fetal
Wear Period: Start ________________ End ________________
Replacement Requested: Yes No

I estimate the dose received during the lost wear period was
____ less than ___ equal to ___ greater than the normal dose exposures I would normally
receive.
Signature ___________________________ Date ________________

Office Use:
Part# __ __ __ Series Code __ __ __ __ __ __ __

UCR Radiation Safety/Lost Badge Form, rev10/28/09