



Albert Einstein College of Medicine

Exposure Information Request Form

Date: _____

To
Previous
Institution: _____

Dear Radiation Safety Officer:

_____, DOB: _____, who is presently associated with Albert
Print Full Name Print Full Date of Birth

Einstein College of Medicine has advised us that _____ was associated with your institution
Print Full Name
from _____ to _____ and while there, worked with radioactive materials and/or radiation producing
(Start Date) (End Date)

Machines. I would appreciate it if you would forward all pertinent previous radiation exposure data for this person to the below address.

Albert Einstein College of Medicine
Attention: James Harold, Radiation Safety Officer
1300 Morris Park Ave
Forchheimer, Room 800
Bronx, NY 10461

This information is requested under the provision of Article 175, New York City Radiological Health code, and Title 10 CFR Part 20, Regulations.

Please see authorization below from _____ to release this information.
(Print Full Name)

Thank you for your cooperation.

Respectfully,
James Harold, Radiation Safety Officer
E-MAIL: james.harold@einsteinmed.edu
PHONE: (718) 430-2243

AUTHORIZATION TO OBTAIN RADIATION EXPOSURE RECORDS

I hereby authorize and request that my radiation exposure records be released to the Albert Einstein College of Medicine's Radiation Safety Office.

(Signature)

(Print Full Name)