

Radiological Work Certificate

To the Safety Office Director, JASRI

I hereby certify that the following person has engaged in radiological work at our organization.

1. Name of worker:

Date of birth: ____ / ____ / ____ (year/month/day). Sex: (male / female)

2. Period of radiological work in radiation-controlled areas.

Period: From Y ____ /M ____ /D ____ to Y ____ /M ____ /D ____

3. Education & training

education & training recently conducted on Y ____ /M ____ /D ____

Law and ordinances on prevention of radiation hazards by radioisotopes and radiation generators:	_____ minutes
Safe handling of radioisotopes and radiation generators:	_____ minutes
Effects of radiation on the body:	_____ minutes

4. Occupational radiation exposure records

a) Accumulated Dose up to March 31, 1989

From Y ____ /M ____ /D ____ to Y ____ /M ____ /D ____ : _____ mrem. Below measurable limit: number of times _____

b) Total Effective Dose Equivalent on or after April 1, 1989

From Y ____ /M ____ /D ____ to Y ____ /M ____ /D ____ : _____ mSv. Below measurable limit: number of times _____

Every fiscal year ; 2016-2020

(FY2016) From Y ____ /M ____ /D ____ to Y ____ /M ____ /D ____ : _____ mSv. Below measurable limit: number of times _____

(FY2017) From Y ____ /M ____ /D ____ to Y ____ /M ____ /D ____ : _____ mSv. Below measurable limit: number of times _____

(FY2018) From Y ____ /M ____ /D ____ to Y ____ /M ____ /D ____ : _____ mSv. Below measurable limit: number of times _____

(FY2019) From Y ____ /M ____ /D ____ to Y ____ /M ____ /D ____ : _____ mSv. Below measurable limit: number of times _____

(FY2020) From Y ____ /M ____ /D ____ to Y ____ /M ____ /D ____ : _____ mSv. Below measurable limit: number of times _____

5. Symptoms of radiation toxicity in the past: Yes / No

6. Abnormalities on health examinations in the past: Yes / No

I hereby witness the above statements

Y ____ /M ____ /D ____

Certifying authority:

Certifying person: Title _____, Name(L) _____ (F) _____

Signature/seal _____