

**RADIOLOGICAL SAMPLING FORM**

**PRIVACY ACT STATEMENT**

AUTHORITY: 10 U.S.C 8013; E.O. 12196; 10 CFR 20.2106; 29 CFR 1910.1096(b)(2)(iii), (n) and (o)  
 PURPOSE: To collect information required to accurately assess dose due to radiation exposure and for entry of this information into the Air Force Master Radiation Exposure Registry (MRER) as required by 10 CFR 20.  
 ROUTINE USES: This information may be disclosed to the NRC for regulatory purposes.  
 DISCLOSURE IS VOLUNTARY: However, failure to provide the requested information will result in failure to accurately assess and post doses per 10 CFR 20.  
 SYSTEM OF RECORDS NOTICE: F044 AF SG O United States Air Force Master Radiation Exposure Registry.

**PART 1 – ADMINISTRATIVE DATA**

|   |                                       |  |  |  |  |           |                                  |  |  |  |  |         |                                       |              |  |  |  |  |  |
|---|---------------------------------------|--|--|--|--|-----------|----------------------------------|--|--|--|--|---------|---------------------------------------|--------------|--|--|--|--|--|
| <b>MAIL SAMPLES TO:</b><br>USAFSAM/OEAL<br>2510 5th St, Bldg 840, Area B<br>Wright Patterson AFB, OH<br>45433 | WORKPLACE OR SITE IDENTIFIER          |  |  |  |  |           |                                  |  |  |  |  |         |                                       |              |  |  |  |  |  |
|   | BASE                                  |  |  |  |  |           |                                  |  |  |  |  |         |                                       | ORGANIZATION |  |  |  |  |  |
|   | WORKPLACE OR SITE                     |  |  |  |  |           |                                  |  |  |  |  |         |                                       |              |  |  |  |  |  |
|   | BUILDING NO./LOCATION                 |  |  |  |  |           |                                  |  |  |  |  |         |                                       | ROOM/AREA    |  |  |  |  |  |
| <b>Send Results To:</b><br><small>(Specify Base Code and Recipient Name)</small>                              | Original                              |  |  |  |  |           |                                  |  |  |  |  |         |                                       |              |  |  |  |  |  |
|   | Copy                                  |  |  |  |  |           |                                  |  |  |  |  |         |                                       |              |  |  |  |  |  |
|   | Email                                 |  |  |  |  |           |                                  |  |  |  |  |         |                                       |              |  |  |  |  |  |
| DATE COLLECTION BEGAN (YYYYMMDD)  | TIME COLLECTION BEGAN (24 HOUR CLOCK) |  |  |  |  |           | DATE COLLECTION ENDED (YYYYMMDD) |  |  |  |  |         | TIME COLLECTION ENDED (24 HOUR CLOCK) |              |  |  |  |  |  |
| SAMPLE COLLECTED BY (Name/Grade/AFSC)   |                                       |  |  |  |  | SIGNATURE |                                  |  |  |  |  | DSN NO. |                                       |              |  |  |  |  |  |

**PART 2 – RADIOLOGICAL SAMPLING DATA**

|  |   |                                  |                                 |          |                                |                                     |                     |                              |  |  |  |  |            |  |  |  |  |  |  |
|--|---|----------------------------------|---------------------------------|----------|--------------------------------|-------------------------------------|---------------------|------------------------------|--|--|--|--|------------|--|--|--|--|--|--|
| <b>BASE SAMPLE NUMBERS</b>                             |   |                                  |                                 |          |                                | <b>From:</b>                        |                     |                              |  |  |  |  | <b>To:</b> |  |  |  |  |  |  |
| Analysis Requested (Select all that apply)             | Sample Type (include surface area/volume) | Subject Information For Bioassay |                                 |          |                                |                                     | Route of Exposure   | Dates Of Exposure (YYYYMMDD) |  |  |  |  |            |  |  |  |  |  |  |
| <input type="checkbox"/> Gamma Spectroscopy            | Environmental, Swipe/Swab                 | Name:                            |                                 | Ht:      |                                | <input type="checkbox"/> Inhalation | From                |                              |  |  |  |  |            |  |  |  |  |  |  |
| <input type="checkbox"/> Alpha Spectroscopy            | Environmental, Air/Water                  | SSN:                             |                                 | Wt:      |                                | <input type="checkbox"/> Ingestion  | To                  |                              |  |  |  |  |            |  |  |  |  |  |  |
| <input type="checkbox"/> Gross Alpha/Beta Counting     | Environmental, Soil/Vegetation            | Sex                              | <input type="checkbox"/> Male   | Pregnant | <input type="checkbox"/> Yes   | <input type="checkbox"/> Injection  | Time(s) of Exposure |                              |  |  |  |  |            |  |  |  |  |  |  |
| <input type="checkbox"/> Liquid Scintillation Analysis | Bioassay, Urine/Fecal/Blood/Other         |                                  | <input type="checkbox"/> Female |          | <input type="checkbox"/> No/NA | <input type="checkbox"/> Absorption |                     |                              |  |  |  |  |            |  |  |  |  |  |  |

**PART 3 – RADIONUCLIDE INFORMATION**

|                |   |
|----------------|---|
| <b>Isotope</b> | <b>Chemical Form/Physical Description/Comments (Action Level required) <i>Inhalation Class required if Bioassay from inhalation exposure.</i></b> |
|                |   |
|                |   |
|                |   |
|                |   |
|                |   |
|                |   |
|                |   |

**Exposure Narrative**  
 Specify Conditions & Requirements for sampling  
 If pre/post-TDY/Mission, detail work and location

**Reason for Bioassay:**  
**(REQUIRED. Sample will not be analyzed without reason.)**

CERTIFICATION STATEMENT: "Based on my understanding of the origin of this sample and/or the process which generated it, I certify that to the best of my knowledge this sample contains no characteristic or listed wastes as defined by 40CFR261" (If the sample does, tell us the nature of the hazardous material).

|      |           |      |
|------|-----------|------|
| NAME | SIGNATURE | DATE |
|------|-----------|------|

## RADIOLOGICAL SAMPLING FORM INSTRUCTIONS

The intent of the sampling form is to capture all pertinent details required to characterize potential exposure to radioactive material. Use of this form does not preclude entry into DOEHS, which should be accomplished as soon as possible to maintain documentation.

*Workplace or Site Identifier:* Base and Customer Code for installation submitting the sample.

*Base:* Name of installation submitting the sample.

*Organization:* Unit/Organization that is submitting the sample.

*Workplace or Site:* Location where the exposure occurred or may occur.

*Building No./Location:* Building/Location where the exposure occurred or may occur.

*Room/Area:* Room/Area where the exposure occurred or may occur.

*Mail Results To:* Base/Customer Code, name of person(s), and email address(es) of individuals that will receive final sample results.

*Date Collection Began:* Date the individual began collecting the sample.

*Time Collection Began:* Time the individual began collecting the sample. Note: current guidance for 24 hour urine samples is to begin collection after the first void of the day.

*Date Collection Ended:* Date the individual finished collecting the sample. For spot samples (non-24 hour samples), use the same date as Date Collection Began.

*Time Collection Ended:* Time the individual finished collecting the sample. For spot samples (non-24 hour samples), use the same time as Time Collection Began. Note: current guidance for 24 hour urine samples is to conclude sample collection with the first void of the next day.

*Sample Collected By:* Individual responsible for submitting the sample to the laboratory.

*Signature:* Signature of individual responsible for submitting the sample to the laboratory.

*DSN No.:* DSN phone number of individual responsible for submitting the sample to the laboratory.

*Base Sample Numbers:* Unique sample numbers, as identified by the installation collecting the sample. The first character of sample number should indicate one of the following collection methods:

|   |           |
|---|-----------|
| C | Composite |
| G | Grab      |

|   |              |
|---|--------------|
| V | Single Void  |
| T | 24 Hour Void |
| W | Wipe/Swipe   |
| O | Other        |

The second character of the sample number indicates the sample type:

|   |                           |
|---|---------------------------|
| U | Urine                     |
| J | Feces                     |
| R | Nasal Swab                |
| Z | Breathing Zone Air Sample |
| O | Other                     |
| S | Soil                      |
| N | Water                     |
| M | Industrial Material       |
| X | Air                       |
| V | Vegetation                |

The following two digits after the sample type will indicate the year. The four digits for the “From” and “To” blocks are designated for unique identifiers. For example, TU-15-0001 is the first 24-hour urine sample from 2015. This form may be used for multiple sequential samples by filling out the prefix (collection method and sample type), then the first four digit sample number, then the last four digit sample number. For example, TU-15-0001-0020 indicates there are 20 “24-hour urine samples from 2015” (ranging from #1 to #20) being submitted under this form.

*Analysis Requested:* If known, indicate preferred analytical method. Optional field – if not populated, lab will determine best analytical method(s) based on radionuclide(s) of interest.

*Sample Type:* Type of sample (Please pick one). Include surface area/volume information in Exposure Narrative section.

*Subject Name:* Name of individual who is being sampled.

*Subject SSN:* Social security number of individual who is being sampled. Required to assess dose and document exposure.

*Ht:* Height of individual being sampled, in inches.

*Wt:* Weight of individual being sampled, in pounds.

*Sex:* Gender of individual being sampled.

*Pregnant:* Whether or not individual being sampled is pregnant.

*Route of Exposure:* How radioactive material entered the body. (May select more than one)

*Dates of Exposure:* Dates exposure began and ended. For example, TDY or mission dates.

*Time of Exposure:* For acute (single intake) exposures, the time radioactive material entered the body.

*Isotope:* Radionuclide(s) to which the individual was, or may be, exposed.

*Chemical Form/Physical Description/Comments:* Physical description of radioactive material. Can include chemical form (e.g., radium paint, depleted uranium munitions, or plutonium oxide).

*Exposure Narrative:* Include all other material documenting the exposure. Example information could include: What were the exposure times during chronic exposures (work day times)? How was the person exposed? How will the person be using the radioactive material? What Personal protective equipment was in use? Etc.

*Reason for Bioassay:* REQUIRED. Why the sample is collected. Options include baseline (pre-exposure), Routine (chronic exposures), and Pre/Post-TDY/Mission.

*Name:* Name of individual submitting sample for analysis.

*Signature:* Signature (electronic, if possible) of individual submitting sample for analysis.

*Date:* Date of sample submission.