State of Colorado
Department of Public Health & Environment
Dosimetry Waiver Request for an Alternative to Continuous Individual Dosimetry Monitoring

INSTRUCTIONS: This application is for approval of an acceptable alternative to the use of continuous individual dosimetry monitoring badges that are used to demonstrate compliance with Sections 4.18.1 and 4.18.2. It must be printed in ink and have original signatures and dates. **Please provide all information requested on this form.** Mail the original completed form with all attachments to the **Colorado Department of Public Health and Environment, HMWMD Radiation Control Program, X-Ray Certification-RM-B2, 4300 Cherry Creek Drive South, Denver, Colorado 80246-1530.** You may also email a copy of the signed, completed form with all attachments to cdphe.hmxraycomments@state.co.us or fax to the number below. A response will be sent within 30 days. Please retain a copy of the completed application form for your records. If you have questions, please call (303) 692-3448 or (888) 569-1831 ext. 3448 toll-free (outside the 303 area code), or fax (303) 759-5355 Attention: X-Ray Certification Unit.

Waiver Request Date:_____	**Facility Type:** (Check One) **____Dental ____Veterinary ____Podiatry ____Chiropractic** **____Medical ____Industrial ____Analytical ____Other**

Section I - Application Information:

Facility Name:		**Facility Registration No.:**
Legal Owner:		
Facility Address:		
City:	**State:**	**Zip Code:**
Business Phone Number:	**Fax Phone Number:**	**Other Phone Number:**
Email Address:		

Section 2 - Approval Request:

I, _____, the undersigned Radiation Safety Officer, certify that:
(Please Print)

1. This is a request for approval of an alternative to the use of continuous individual dosimetry monitoring badges per the requirements of Part 4, Section 4.18.3 of the Colorado *Rules and Regulations Pertaining to Radiation Control,* 6 CCR 1007-1.
2. The alternative method used will be (check one):
   - ☐ **Dosimetry Monitoring Reports –** attached are copies of the most recent six months of radiation dosimetry monitoring reports showing that the radiation workers at this facility are below 10% of the annual radiation limits listed in 6 CCR 1007-1, Section 4.6,
   - ☐ **Qualified Expert report** – attached is a copy of the radiation level assessment by a Registered Qualified Expert performed as described in Section 4.18.3.1(2).
3. The radiation dosimetry monitoring program used at the facility listed above is current and that the review of the Radiation Protection Program requirements of 6 CCR 1007-1, Part 4, Section 4.5 is current.
4. I have reviewed the Radiation Protection Program for the facility per the requirements of Section 4.5 on an annual basis and have determined that it is appropriate for this facility to cease continuous individual dosimetry monitoring.
5. I understand this approval is only valid for this facility at the address stated above.
6. I understand that a change of address, adding additional x-ray machines, remodeling the x-ray room or failing to meet the requirements of 6 CCR 1007-1, Part 4, Section 4.5 Radiation Protection Program, will void the approval.
7. I understand that the monitoring of **minors** must be done per the requirements of Section 4.18.1.2.
8. I understand that monitoring of **declared pregnant workers** must be done per the requirements of Sections 4.13 and 4.18.1.3.
9. This facility's registration information is current and there are no outstanding facility or machine violations.
10. The information contained in this approval request is, to the best of my knowledge, true, accurate, and complete in all respects.
11. I am fully authorized to make this approval request on behalf of this facility and will keep this request on file with the formal written notification of the Department's approval or denial.

Signature of Radiation Safety Officer:_____Date:_____

For Office Use Only

_____Approved _____Denied (Justify in space below)

Signature of Reviewer:_____ Date:_____ Title:_____

Signature of Administrative Staff:_____ Date:_____ Date of Completion/Mailing:_____
Comments: (If approval is denied, substantiate with a brief statement and make recommendations if further action is required)