

# Radiation Worker Registration Form

Date: \_\_\_\_\_ (Year/Month/Day)

Please make sure the head of your institution fills out this part  
To the Director of RCNP

Institution: \_\_\_\_\_

Name of Approver, Position: \_\_\_\_\_

Signature of Approver: \_\_\_\_\_

I authorize the applicant named below to engage in radiation work from

2017/04/01 to 2018/03/31 (within a fiscal year \*1) as follows:  
Year/Month/Date Year/Month/Date

Please check either of the check box.

- ☐ I authorize the applicant to engage in radiation work at RCNP, certifying that our institute will conduct radiation management for the applicant. (Please fill in the Certification part below)
- ☐ I authorize the applicant to engage in radiation work on RCNP, under the radiation management. (Limited to cases where the applicant is not engaged in such work at his/her home institute but mainly at RCNP.) \*The copy of your medical examination, certification of recent education on radiation protection, and past radiation exposure are required.

## Applicant Information PLEASE WRITE CLEARLY IN BLOCK LETTERS

Name	Full Name	Gender	<input type="checkbox"/> M <input type="checkbox"/> F
		Birthdate	(Year/Month/Day)
		Telephone	
Email		Position	
Address*			

\*Applicant's dose report will be sent to this address

## Certification

Date of the recent safety training and medical examination.

Please make sure your Radiation Protection Supervisor fills out this part.

I certify that the person above is an authorized radiation worker, and that he/she has completed the necessary components stated below.

### 1. Date of Recent Education on Radiation Protection ( Date must be within a year of registration )

( \_\_\_\_\_ Year/Month/Day )

### 2. Recent Medical Examination \*2

( \_\_\_\_\_ Year/Month/Day ) ☐ no apparent abnormalities

Please check if you had no abnormalities on your medical examination

Institution \_\_\_\_\_

Radiation Safety Officer (Signature) \_\_\_\_\_

(continue to next page)

Please check the applicable box.

<b>Cooperative Researcher Application Form</b>	<div><input type="checkbox"/>Already handed in    <input type="checkbox"/>Enclosed <input type="checkbox"/>Will be handed in later</div>
<b>Contact Person at RCNP *3</b>	Authorized RCNP faculty's name

\*1 Registration date is effective only within one Japanese fiscal year (from April 1 to March 31 of the following year)

\*2 Medical Examination components required by the Japanese law are as follows:

1. Past radiation exposure (if any: the time, place, and the amount of exposure)
2. Blood test (hematocrit value, red and white blood cell count)
3. Skin check
4. Eye exam (cataract screening)

Please make sure to have the examination done before coming to RCNP.

\*3 Authorized RCNP faculty only

Inquiries: [radiation-control@rcnp.osaka-u.ac.jp](mailto:radiation-control@rcnp.osaka-u.ac.jp)

Return completed form to: 10-1 Mihogaoka Ibaraki, Osaka JAPAN

567-0047

Research Center for Nuclear Physics, Osaka University

Radiation Control Office