

**UNIVERSITY OF MINNESOTA
RADIATION PROTECTION DIVISION**

QUARTERLY REPORT

Permit Holder: _____

Quarter reported: 1st 2nd 3rd 4th

Department: _____

Year: _____

Campus: _____

A copy of this form must be completed and sent to the Radiation Protection Division (RPD) at the end of each calendar quarter. Keep the original on file for review by the RPD and/or NRC. Failure to submit a quarterly report by the appropriate due date will result in the suspension of your privileges to order and/or receive radioactive materials.

Due Dates: Your report should reach the RPD at W-140, Boynton Health Service, by the dates indicated following each calendar quarter.

First Quarter (Jan, Feb, Mar) due by: **April 1st**
Second Quarter (Apr, May, Jun) due by: **July 1st**
Third Quarter (Jul, Aug, Sep) due by: **October 1st**
Fourth Quarter (Oct, Nov, Dec) due by: **January 1st**

Inventory Date determined: _____	Radio- Isotope	Inventory Activities (mCi)		
		Stock	Waste	Total
Report the inventory for each radioisotope listed on your permit (even if it is zero). The activity you report for stock material and waste must be decay corrected to the date you have indicated above.	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Refer to Appendix CC for instructions on decay correction of radioactive waste.	_____	_____	_____	_____

Personnel

List and denote the names of those staff members who are new (**A**:add), have changed their names (**C**:change), or who no longer work under your permit (**D**:delete) since the last quarter. Attach additional pages if needed.

Restricted Radioisotope Areas (labs, cold rooms, etc.)	Building	Room	Status (check one)
List all areas where radioisotopes are handled or stored, and indicate the status of each area according to the following designations:	_____	_____	A or S
	_____	_____	A or S
(A) Active: Handling and use of rad-materials during quarter.	_____	_____	A or S
(S) Storage: Storage only, no removal or use during quarter.	_____	_____	A or S
	_____	_____	A or S

Report completed by _____ Date _____ Phone _____

Permit Holder:	Dept.:	
Surveyed by:	Phone:	Date:
Building:	Room Number(s):	
Insert map of room(s) and indicate doorway number(s)		

Smear Survey Data			Exposure Rate (G.M.) Survey Data		
Radioisotopes Analyzed:			Instrument Used:		
Counting Efficiencies (%):			Background CPM or mR/hr:		
Instrument Used:			No.	Location	CPM or mR/hr
No.	Location	DPM/100 cm ²			
Continue on back					

If contamination is detected, decontaminate to < 250 DPM/100 cm² . Document decontamination results on this form. Eating, drinking, smoking, cosmetic application and mouth pipetting are prohibited in all radioactive material areas.

