

Registration
as experimentalist / user
at the TRIGA research reactor Mainz (FRMZ)

JOHANNES GUTENBERG-UNIVERSITÄT MAINZ - 55099 Mainz

Family name, first name, titel: _____

Date and place of birth, if applicable name at birth: _____

Residential address: _____

E-mail-adress: _____

Name of home institution: _____

Division & adress: _____

Institut für Kernchemie
TRIGA Forschungsreaktor

Johannes Gutenberg-Universität Mainz
Fritz-Strassmann-Weg 2
55128 Mainz

Sekretariat:
Petra Sach-Muth
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Fax +49 6131 39-24510
petra.sach-muth@uni-mainz.de

Radiation protection issues:

the radiation protection surveillance of the above mentioned person during her/his visit at the FRMZ will be pursued by the radiation protection division of

- the users home institution (*preferred*)
[→ Form „Declaration from radiation protection department”]
- the FRMZ [→ Form „Medical certificate “]

Which kind of dosimetry will be provided by your home instution while working at the FRMZ?

Official, passive Albedo-dosimeter

Electronical dosimeter

None

Date

Signature user/visitor at FRMZ

NOTE

This form has to be submitted to the FRMZ latest 5 weeks before the first visit! Delayed submission might lead to restricted or even refused access to the FRMZ.

With her/his signature the user/visitor agrees, that her/his personal data will be submitted according to German law to the corresponding authorities for a security check.

Due to aspects of radiation protection, no access can be provided to persons which have not reached their 16th anniversary as well as for pregnant and breast-feeding women.

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PROOF OF EMPLOYMENT

(to be filled out from all users)

for users at the Research Reactor TRIGA Mainz (short: FR MZ)

This document is to certify, that

Name (as in passport) _____

First name(s) _____

Date of birth (day/month/year, in figures) _____

is employed at the

Department of home Institution: _____

Home Institution full name: _____

Adress: _____

until

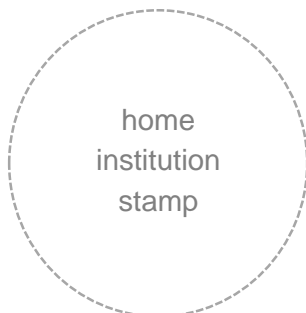
expiration of contract: _____

and therewith during her/his visit at the University of Mainz and especially at the FR MZ. She/he will be insured for medical expenses and work accidents during his visit and while working at the University of Mainz, as well as against disability arising from work accidents, during her/his stay at the University of Mainz.

Date of certification:
(day/month/year, in figures)

Name of signing person in printed letters

Function at home institution of signing person



Signature

JOHANNES GUTENBERG-UNIVERSITÄT MAINZ - 55099 Mainz

MEDICAL CERTIFICATE

for users at the Research Reactor TRIGA Mainz (short: FRMZ)

As a result of the medical examination performed on:

Name (as in passport) _____

First name(s) _____

Date of birth (day/month/year, in figures) _____

Name of institute _____

I hereby declare that he/she:

MAY BE ADMITTED to radiation areas with work which can comprise a professional exposure to the ionizing radiation. (N.B.: except explicit restriction, the period of validity of aptitude is 12 months)

MAY BE ADMITTED BUT WITH RESTRICTION: (please precise)

SHOULD NOT BE ADMITTED to radiation areas

Date of examination:
(day/month/year, in figures)

Signature and stamp
of Medical Practitioner

NOTE TO THE MEDICAL PRACTITIONER

- 1) This examination is essential to ensure that there is no medical contraindication which would prevent this person from being exposed to ionizing radiation during the exercise of his/her profession.
- 2) The examination should include a clinical and hematological examination (red and white cells, platelets, differential count).
- 3) The medical certificate must be given by the person or his/her representative to the radiation protection division of the FR MZ. **This certificate must not be submitted by mail/fax !**

P.S: These examinations are not paid by FRMZ or other institutions of the Johannes Gutenberg-University

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DECLARATION FROM RADIATION PROTECTION DEPARTMENT
at the home institution of external users at the TRIGA research reactor Mainz (FRMZ),

This document is to certify, that

Name (as in passport) _____

First name(s) _____

Date of birth (day/month/year, in figures) _____

is part of the radiation protection surveillance in our institution.

Within the last two years she/he experienced a collective effective dose rate of

Collective dose rate of last two years : _____ **mSv.**

Other restrictions from radiation protection point of view against working in the controlled areas (category A)

do not apply.

are as follows: _____

please specify: _____

Date of certification:
(Day/month/year)

Name of radiation protection officer
in capital letters

Radiation protection officer telephone number

Signature of radiation protection officer

