**FORM M-C**

**REQUEST FOR CLOSURE MEDICAL EXAMINATION**

**FOR PERSONNEL EXPOSED TO IONISING RADIATION**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Structure name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Section**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby, is requested to submit the listed below staff at the scheduled medical check-up:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name and Surname | | Qualification(1) | Classification of the | Date of termination |
|  |  |  | Activity (2) | of workers (3) | |

Signature of the Radiation Protection Expert:

Signature of the Director of the facility:

Signature of Worker:

**Notes:**

|  |
| --- |
| 1. Report the qualification of the radio-exposed personnel: teacher, technical-administrative staff, student, research grant holder, post   graduate student, trainee, graduate student, doctoral student, guest speaker (specifying the Body/Company to which they belong).  (2) Indicate the classification of the personnel: exposed Category A worker, exposed Category B worker.  (3) Indicate the date of effective termination of the activity involving exposure to ionising radiation, specifying whether, at the same time,  the employment relationship will be terminated. |