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## **Instructions for Filling out Shielding Integrity Request Form**

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Please follow directions below to ensure timely response to your shielding integrity request.

1. Please fill out the shielding design spec form below completely. Any missing information may slow down the completion of the shielding design. Note: We must have a physical address for the facility.
2. Attach a **scale drawing** of room(s) – (e.g. scale  $\frac{1}{4}'' = 1$  foot). Drawing **must** have all surrounding areas on the drawing labeled (e.g. storage closet, corridor, office space, hallway, exterior, bathroom).
3. **For radiographic rooms** – please specify on drawing location of wall bucky.
4. **For all rooms** – please specify on drawing location and orientation of radiation producing unit.
5. Please have position of operator barrier, if applicable, labeled as well.

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## Existing Shielding Specifications

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Send completed forms with all drawings to Fax: (888) 213-5538 or Email: [info@PrismPhysics.com](mailto:info@PrismPhysics.com)  
Please note that the dimensions of a radiographic room must be 8' x 10' or greater.

**Date of Request:** \_\_\_\_\_

**Provide the full business name and address of the physical location where the room(s) is/are located**

Facility Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Name and mailing address (for all correspondence, if different from physical location)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Project No.: \_\_\_\_\_ P.O. #: \_\_\_\_\_

**Name and address of person responsible for payment:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Project No.: \_\_\_\_\_ P.O. #: \_\_\_\_\_

**PLEASE SKIP THE FOLLOWING SECTION IF YOU ARE PROVIDING AN EXISTING SHIELDING DESIGN REPORT**

Equipment (*e.g. CT, X-Ray, Mammo, DEXA, PET, C-Arm, etc.*): \_\_\_\_\_

Vendor/Model of Equipment: \_\_\_\_\_

Room ID (*e.g. CT room, X-Ray room*): \_\_\_\_\_

Area **above** each room (*e.g. roof, office space, attic, etc.*) \_\_\_\_\_

Area **below** each room (*e.g. slab on grade, basement, etc.*) \_\_\_\_\_

For **multi-story** facilities, please provide composition & thickness of  
building material between floors (*if available*): \_\_\_\_\_

Total number of cases expected to be performed each: Day: \_\_\_\_\_ Week: \_\_\_\_\_

For **Fluoro rooms** the approximate time spent on each case: \_\_\_\_\_ Minutes

**\*\*\* Please note that fees are due according to terms of agreement\*\*\***