Radiation Shielding Design Request Form
Dental

Contact Information

Facility Name _____ ***Room ID or Number*** _____

Street Address _____ ***State*** _____

City _____ ***Zip Code*** _____

First Name _____ ***Last Name*** _____

Title _____ ***Company*** _____

Email _____ ***Phone*** _____

Equipment Information and Workload

Manufacturer _____ ***Model*** _____

Estimated Maximum # Patients Per Week _____ ***Estimated Maximum # Images Per Week*** _____

Maximum kVp _____ ***Type of Dental Use*** ☐ *Intraoral* ☐ *Panoramic* ☐ *CBCT* ☐ *Other* _____

Average mAs per exposure: _____

Construction Information

Construction Type
- ☐ *New Construction*
- ☐ *Remodel of Existing Building*
- ☐ *Remodel of Existing Shielded Rm*
- ☐ *Equipment Replacement*
- ☐ *Other* _____

Is There a Previous or Existing Shielding Design For This Space? ☐ *Yes* ☐ *No*

Is This a Multiple Story Building? ☐ *Yes* ☐ *No*

****If YES, please answer the additional questions below.***

Which Floor Is the Room On? _____ ***What Is The Floor to Floor Height?*** _____

What Is The Floor / Ceiling Building Material? _____

What Is The Floor / Ceiling Building Thickness? _____

Are There Occupied Spaces Above or Below? ☐ *Above* ☐ *Below* ☐ *Both*

What Is Above or Below? _____

Describe the areas that are on the opposite sides of each wall (ie: office space, work areas, hallways, bathrooms, etc.)

_____

_____

_____

All walls are assumed to contain standard gypsum wallboard with a total thickness of 1.25". If additional materials are known to be present, please list known compositions and thicknesses (ie: 0.79 mm of lead, 8 inches of concrete).

_____

_____

_____

Comments

Please include a scale (1/4") drawing of the room in PDF format. The drawing should include the placement and orientation of equipment as well as surrounding spaces.

Please submit this form to info@olympichp.com. For questions, call 253.254.6988.

OLYMPIC
HEALTH PHYSICS