RS-9 / Radiation Incident Report

Report Preparation

Report prepared by: _____

Title / Department: _____

Signature: _____ Date: _____

Authorized User, if applicable: _____

SECTION 1 – Incident Information

Location of incident: _____
(Building / Room)

Date / time of incident: _____
(Date: MM/DD/YYYY, Time: AM/PM)

Radiation source involved:

☐ Radioactive material

☐ Sealed source/device

☐ Radiation machine

☐ Other: _____

Radionuclide(s), if applicable: _____

Estimated activity, if applicable: _____ mCi

Machine/device/source identification, if applicable: _____

SECTION 2 – Initial Notification

Date / time incident discovered: _____
(Date: MM/DD/YYYY, Time: AM/PM)

Date / time RSO notified: _____
(Date: MM/DD/YYYY, Time: AM/PM)

Person who notified RSO: _____

Person receiving notification: _____

Method of notification: ☐ Phone ☐ Email ☐ In person ☐ Other: _____

SECTION 3 – Incident Description and Initial Response

Provide a detailed description of the incident. Answer questions below, as applicable. If more space is needed, attach additional sheets.

Additional sheets attached? ☐ Yes ☐ No

What happened? _____

_____

_____

_____

_____

_____

_____

_____

_____

Name(s) of individuals present: _____

_____

_____

Injuries sustained? ☐ **Yes** ☐ **No** **(if yes, describe):** _____

_____

_____

_____

_____

Personnel contamination? ☐ **Yes** ☐ **No** **(if yes, describe):** _____

_____

_____

_____

Immediate actions taken: _____

_____

_____

_____

Equipment/property damage, if any: _____

_____

_____

_____

Area contamination suspected or confirmed? ☐ Yes ☐ No

If yes, describe: _____

_____

_____

Area secured/restricted? ☐ Yes ☐ No ☐ N/A

Contamination remaining after decontamination? ☐ Yes ☐ No ☐ N/A (if yes, describe):

_____

_____

_____

Additional comments/notes: _____

_____

_____

_____

SECTION 4 – RSO Evaluation and Investigation

Surveys performed: ☐ Yes ☐ No ☐ N/A

Survey records attached: ☐ Yes ☐ No ☐ N/A

Personnel dose evaluation required: ☐ Yes ☐ No ☐ N/A

Bioassay/medical evaluation considered or required: ☐ Yes ☐ No ☐ N/A

Material/source accounted for: ☐ Yes ☐ No ☐ N/A

Area released for normal use: ☐ Yes ☐ No ☐ N/A

Date/time released: _____

Apparent/root cause: _____

_____

_____

_____

Corrective actions required: _____

_____

_____

_____

Regulatory / Administrative Notification Evaluation

Regulatory notification required: ☐ Yes ☐ No ☐ Pending evaluation

If required:

Agency notified: _____

Date/time: _____

Person making notification: _____

Report/reference number, if applicable: _____

Other institutional notification required: ☐ Yes ☐ No

Details: _____

_____

_____

SECTION 5 – Corrective Actions and Closeout

Corrective actions completed: _____

_____

_____

_____

Additional training required: ☐ Yes ☐ No

Procedure/SOP revision required: ☐ Yes ☐ No

Permit/authorization modification required: ☐ Yes ☐ No

Additional follow-up required: ☐ Yes ☐ No

Regulatory notification determination finalized: ☐ Yes ☐ N/A

Comments / follow-up documentation: _____

_____

Incident closed: ☐ Yes

Closure date: _____

RSO name: _____

Signature: _____ Date: _____