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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **CLIENT INFORMATION  FOR NEW APPLICATION FOR RENEWAL OF SERVICE** | | | | | | | | | | | | | | |
| 1. Complete Facility Name: | |  | | | | | | | | | | | | |
| 1. Type of Office | | Main  Branch Others: | | | | | | | | | | | | |
| 1. Facility Address 1: | |  | | | | | | | | | | | | |
| Facility Address 2: | |  | | | | | | | | Zip Code | | |  | |
| 1. Contact Person: | |  | | | | | | | | Designation: | | |  | |
| 1. Billing Address: | |  | | | | | | | | | | | | |
| 1. Bill-To Person: | |  | | | | | | | | Designation: | | |  | |
| 1. Tel No.: | |  | | | | | | | | Mobile No. | | |  | |
| 1. Company TIN.: | |  | | | | | | | | E-mail: | | |  | |
| **2. RADIATION EMITTING EQUIPMENT** *(Use additional sheets if necessary)* | | | | | | | | | | | | | | |
|  | | ***Brand*** |  | | ***Model*** | | | |  | | | ***Details (kV and mA)*** | | |
| 1. X-ray | |  |  | |  | | | |  | | |  | | |
| 1. CT-Scan | |  |  | |  | | | |  | | |  | | |
| 1. Mammography | |  |  | |  | | | |  | | |  | | |
| 1. Other: (Specify) | |  |  | |  | | | |  | | |  | | |
| 1. **RADIATION DETECTORS AND PERSONAL PROTECTIVE EQUIPMENT** | | | | | | | | | | | | | | |
| 1. Radiation Detector  Survey Meter  Pen Dosimeter Others: | | | | | | | | | | | | | | |
| 1. Protective Equipment  Lead Gown  Lead Goggles  Thyroid Shield Others: | | | | | | | | | | | | | | |
| 1. **USER/S INFORMATION** | | | | | | | | | | | | | | |
|  | **Name *(Last Name, First Name, Middle Initial)*** | | | **Gender** | | **Designation** | | | | | **Department Name** | | | **Pregnant (Y/N)** |
| 01 |  | | |  | |  | | | | |  | | |  |
| 02 |  | | |  | |  | | | | |  | | |  |
| 03 |  | | |  | |  | | | | |  | | |  |
| 04 |  | | |  | |  | | | | |  | | |  |
| 05 |  | | |  | |  | | | | |  | | |  |
| 06 |  | | |  | |  | | | | |  | | |  |
| 07 |  | | |  | |  | | | | |  | | |  |
| 08 |  | | |  | |  | | | | |  | | |  |
| 09 |  | | |  | |  | | | | |  | | |  |
| 10 |  | | |  | |  | | | | |  | | |  |
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| 12 |  | | |  | |  | | | | |  | | |  |
| 13 |  | | |  | |  | | | | |  | | |  |
| 14 |  | | |  | |  | | | | |  | | |  |
| 15 |  | | |  | |  | | | | |  | | |  |
| 1. **NUMBER OF BACKGROUND CONTROL BADGES** | | | | | | **SPECIFY LOCATION** | | | | | | | | |
| 01 |  | | | | |  | | | | | | | | |
| 02 |  | | | | |  | | | | | | | | |
| 03 |  | | | | |  | | | | | | | | |
| ***NOTE: Should you have more than 15 users or more than 3 background control badges, kindly place details in an attached sheet.*** | | | | | | | | | | | | | | |
| 1. **SUBSCRIPTION PLAN** | | | | | | | | | | | | | | |
| **Monthly Monitoring**  \*Receives 12 dose reports in a year | | | | | | | | **Bi-Monthly Monitoring**  \*Receives 6 dose reports in a year | | | | | | |
| 1. **TYPE OF DELIVERY**  LBC N/A (For Pick-Up) | | | | | | | | | | | | | | |
| 1. **BADGE SUMMARY** | | | | | | | | | | | | | | |
| **Total No. of Users:** | | | | | | | **Total No. of Background Badges:** | | | | | | | |
| ***NOTE: Prices are VAT inclusive. Prices include free assessment of dose badges, delivery of dose reports. Prices are subject to change without prior notice.*** | | | | | | | | | | | | | | |
| 1. **AGREEMENT.**   *By ticking this box, it is understood that all information provided in this application is true, correct and complete. I accept the terms and conditions of subscription to OSLD Dosimetry Services provided by TÜV Rheinland Philippines, Inc., including any amendments thereto.* | | | | | | | | | | | | | | |
| **Full Name of Representative** | | | | | | | | | | **Date Signed** | | | | |

*Kindly send this completed form to* [*oslservice@tuv.com*](mailto:oslservice@tuv.com) *or directly submit it to our office. Upon our acknowledgement, a quote will be sent to you with the corresponding breakdown of fees. You will receive your badges through your preferred delivery type* ***15 working days*** *after we have received a copy of your full payment receipt. For questions or clarifications, please feel free to contact us at +63 2 8246 1670.*