

14.7 What were your location and activities during the incident? _____

What precautions were taken to protect you? _____

What types of personal protective equipment, if any, did you use? _____

How long were you exposed during the incident? _____

Did you receive chelation therapy or other medical treatment as a result of radiation exposure from this incident? Yes
 No
 Don't Know

IF "NO" OR "DON'T KNOW" GO TO QUESTION 14.12, IF "YES":
Please describe the medical treatment you received:

Chelation Therapy

Other Medical Treatment

14.12 Did you receive biological monitoring after the incident? Yes
 No

IF "NO" GO TO QUESTION 15, IF "YES":

14.13 What type of biological monitoring? whole body measurement
 urine
 fecal
 breath

14.14 Do you have records of this monitoring? Yes
 No

IF "NO" GO TO QUESTION 15, IF "YES":

Are you willing to provide copies of these records to NIOSH?
 Yes
 No

IF "YES" GO TO QUESTION 15, IF "NO" EXPLAIN THE IMPORTANCE OF THIS INFORMATION AND ADDRESS ANY CONCERNS, AS FEASIBLE. IF THE ANSWER REMAINS NO:

14.16 Why not? _____

Section 6: Required medical screening x rays

Some workers were required to periodically have medical x rays as a condition of employment:

15. Were you ever required to have medical x rays for this job, as a condition of employment?

Yes
 No

IF "NO" GO TO QUESTION 16, IF "YES" :

15.1 How often were you x-rayed, and over what time period(s)?

Time Period	Frequency of x rays

15.2 Do you have records of these x rays?

Yes, for all x rays
 Yes, for some x rays
 No

IF "NO" GO TO QUESTION 16, IF "YES":

15.3 Would you provide us with copies of these records?

Yes
 No

Section 7: Other relevant information

We're nearly done reviewing this job. This is an opportunity for you to identify other relevant information that might help us complete your dose reconstruction:

16. Have we missed asking you about any conditions, situations, or practices that occurred during this job which you think may be useful to us in estimating your radiation doses?

Yes
 No

IF "NO", GO TO QUESTION 17, IF "YES":

16.1 Describe this with as much detail as possible, in terms of what occurred, where, when, for how long, and who was involved:

17. Are you aware of any records related to the information you have provided that may help us estimate your doses? ___ Yes: Source/Type

____ Personal Physician
____ Site Medical Records
____ Incident Reports
____ Safety Meeting Notes
_____ Other (describe)
____ No

IF "NO" AND THIS IS THE LAST JOB TO REVIEW, GO TO QUESTION 18.

IF "YES" AND THE RECORDS ARE FROM A PERSONAL PHYSICIAN, ASK THE CLAIMANT TO OBTAIN AND PROVIDE THE RELEVANT MEDICAL RECORDS TO NIOSH.

NOTE: COMPLETE SECTIONS 3-7 FOR EACH JOB LISTED IN QUESTION 1.

Section 8: Final Questions – Identifying co-workers and other witnesses

Depending on what information is available to us from DOE and other sources, we may or may not need to try to speak with your supervisors, co-workers, or others who can help us with your dose reconstruction. However we would like help from you now, so that we can contact others efficiently if we need to.

18. Can you name co-workers or other witnesses, such as consulting industrial hygienists or radiation safety specialists, who can confirm or expand upon the information you have provided us?

- Yes
- No

IF "YES", OBTAIN UP TO FIVE NAMES AND ANY CONTACT INFORMATION AVAILABLE:

1. _____
2. _____
3. _____
4. _____
5. _____

THAT'S IT! THANKS FOR TAKING THE TIME TO ANSWER ALL THESE QUESTIONS. WE REALLY APPRECIATE YOUR HELP. DO YOU HAVE ANY QUESTIONS ABOUT THE DOSE RECONSTRUCTION PROCESS OR CLAIMS PROCESS, FROM HERE FORWARD?
