BIOASSAY SAMPLE FORM

Last Name:_____First Name: _____Middle Initial: _____

S.S.N./P.I.N.:_____ Organization: _____

Address: _____

Date (dd-mm-yy):_____AWP Number: _____

Sample Media: ___ Urine ___ Fecal ___ Thyroid ___ Lung

___ Wound ___ WBC ___ Nasal ___ Other (specify): _____

Sample Number : Time (hhmm)

Comments: _____

Sample Type: ____ Baseline ___ Routine ___ Post-Work ___ Other_____

Analyses:

Time/Date of Sample Collection: Begin: _____ End: _____

Chain of Custody

Relinquished By (Signature)	Date/Time (Relinquished)	Date/Time (Received)	Received By (Signature)

Privacy Act Statement: *The information on this form is protected by the Privacy Act of 1974. The purpose of requesting this information is to conduct dose tracking. This information will be used by the U.S. Department of Energy, Nevada Operations Office, its contractors, and the home organization of the participant. Failure to provide this information will result in not receiving a dose assessment or proper dose tracking.*