



**MARYLAND DEPARTMENT OF THE ENVIRONMENT**  
**Radiological Health Program (RHP) Reciprocity Work Notification**

1800 Washington Boulevard • Baltimore, Maryland 21230

MDE/RHP Phone# 410-537-3300 After Hours Emergency 1-866-633-4686 [www.mde.maryland.gov](http://www.mde.maryland.gov)

This form must be received by the RHP at least three (3) working days prior to using radioactive material (RAM) in Maryland. Authorization to use radioactive material under reciprocity shall not exceed 180 calendar days in any year. Failure to notify RHP at least three working days prior to entering the state or to truthfully complete the notice may result in a *NOTICE OF VIOLATION* and repeated violations may result in revocation of reciprocity to work in Maryland. Attach additional copies of this form per device as needed.

**1. Service Company Information**

Notification # \_\_\_\_\_  
 Company \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone # \_\_\_\_\_  
 License # \_\_\_\_\_  
 RSO Name \_\_\_\_\_  
 MDE Requirements Letter Recd. Date \_\_\_\_\_

Total days worked in MD \_\_\_\_\_  
 MD REC Number \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip# \_\_\_\_\_  
 Email \_\_\_\_\_  
 Expiration Date \_\_\_\_\_  
 Contact No. \_\_\_\_\_  
 Type of Work \_\_\_\_\_

**2. Equipment Information**

Device \_\_\_\_\_  
 Model \_\_\_\_\_  
 Q.M. Inspection Date \_\_\_\_\_  
 Vehicle ID (Make/Model) \_\_\_\_\_  
 License# \_\_\_\_\_

Manufacturer \_\_\_\_\_  
 S/N \_\_\_\_\_  
 Storage Method \_\_\_\_\_  
 State \_\_\_\_\_  
 Year \_\_\_\_\_

**3. Source Information**

Isotope \_\_\_\_\_  
 Manufacturer \_\_\_\_\_  
 Leak Test Date \_\_\_\_\_

Activity \_\_\_\_\_  
 Model \_\_\_\_\_ S/N \_\_\_\_\_

**4. Job Site Information**

Date(s) of use (weekday/weekend) \_\_\_\_\_  
 Client Name \_\_\_\_\_  
 Client Contact # \_\_\_\_\_  
 Job site location(s) \_\_\_\_\_

Time of use (am/pm) \_\_\_\_\_  
 Person in charge \_\_\_\_\_  
 Federal  Non-Federal

**5. Company Representative/s**

**Name**

**Cell Phone #**

Radiographer \_\_\_\_\_  
 Assistant Radiographer \_\_\_\_\_  
 Technician \_\_\_\_\_  
 Service Person \_\_\_\_\_  
 Other \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Additional Requirements**

- Notify RHP by 0900 hrs. if work not performed
- Notify RHP by 1600 hrs. if after hours work not performed
- Notify RHP any time submitted work times are rescheduled or changed
- Notify RHP if personnel leave site less than 1/2 time requested

I hereby certify that all information on this notice is true and complete.

RSO signature \_\_\_\_\_ Date \_\_\_\_\_