

STATE OF GEORGIA

Radioactive Materials Program
404/362-2675
FAX 404/362-2653

NOTIFICATION OF RECIPROCITY

DATE	_____		
REQUESTING COMPANY	_____		
CONTACT PERSON	_____		
TELEPHONE	_____		
ADDRESS	_____		
CITY/STATE/ZIP	_____		
LICENSED IN (STATE OF):	_____		
LICENSE NUMBER:	_____		
AUTHORIZED USER(S)	_____		
RADIOGRAPHY ¹	YES ___ NO ___ <i>(Please fax a copy of certification card(s) with request.)</i>		
EMPLOYING COMPANY	_____		
ADDRESS	_____		
CONTACT PERSON	_____		
TELEPHONE	_____		
JOB LOCATION (Street Address)	_____		
START DATE/END DATE	_____ / _____		
START TIME/END TIME	_____ / _____		
DEVICE NAME	#1	#2	#3
MODEL #	_____	_____	_____
SERIAL #	_____	_____	_____
SOURCE NAME	_____	_____	_____
ISOTOPE	_____	_____	_____
MODEL#	_____	_____	_____
SERIAL#	_____	_____	_____

1. The State of Georgia requires a certified two-person crew for radiography.