

U.S. Radiologic Technologists Study

A collaborative effort between the University of Minnesota School of Public Health, National Cancer Institute, and American Registry of Radiologic Technologists

RADIOISOTOPE PROCEDURES QUESTIONNAIRE

Instructions:

- Use blue or black ink
- Print legible numbers:

1	2	3
---	---	---
- Mark an **X** in the box:

Right	Wrong
<input type="checkbox"/>	<input type="checkbox"/>
- Do not make any stray marks on this form. If you have comments, please write them on a separate piece of paper.

This questionnaire is focused on:

- **DIAGNOSTIC** radioisotope procedures: (Section 1, pages 1-5) and
- **THERAPEUTIC** radioisotope procedures: (Section 2, pages 6-8).

Some information from the past may be difficult to recall. Just do your best. Even if not exact, your best estimates are valuable to the study.

SECTION 1: DIAGNOSTIC RADIOISOTOPE PROCEDURES

1. Did you ever perform or assist with **DIAGNOSTIC RADIOISOTOPE** procedures at least once a WEEK for a year or more?

NO → Go to Page 6, Question 11.

YES (Please continue with survey.)

2. What years did you **FIRST** and **LAST** perform or assist with **DIAGNOSTIC RADIOISOTOPE** procedures at least once a WEEK?

--	--	--	--

FIRST YEAR

--	--	--	--

LAST YEAR (Enter current year if still working with procedures.)

3. During each time period, how many **YEARS** did you perform or assist with **DIAGNOSTIC RADIOISOTOPE** procedures at least once a week?

Number of YEARS				
1945-1964	1965-1979	1980-1989	1990-1999	2000-2009

4. During each time period, how many total **TIMES** per **WEEK** did you usually perform or assist with **DIAGNOSTIC RADIOISOTOPE** procedures?

Total Number of TIMES per WEEK				
1945-1964	1965-1979	1980-1989	1990-1999	2000-2009

NOTIFICATION TO RESPONDENT OF ESTIMATED BURDEN

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0405). Do not return the completed form to this address.

--

5. For the following DIAGNOSTIC RADIOISOTOPE procedures, please provide your best estimate of how many **TIMES per WEEK** you performed or assisted with these procedures during each time period.

Please provide estimates for all procedures you performed in each group (e.g. all thyroid scans) and also for procedures within each group that you performed using the selected radiopharmaceutical listed. If you used more than one radiopharmaceutical for a given procedure, please answer separately for each radiopharmaceutical. NOTE: Leave all time period boxes blank if you NEVER worked with a procedure; leave specific time period boxes blank if you worked with a procedure less than once a week during that time period.

DIAGNOSTIC PROCEDURE	RADIOPHARMACEUTICAL	NEVER	How many TIMES per WEEK did you perform these procedures in each time period?				
			1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
All Thyroid scans		<input type="checkbox"/>					
Thyroid scan	¹³¹ I-sodium iodide.....	<input type="checkbox"/>					
	¹²³ I-sodium iodide.....	<input type="checkbox"/>					
	^{99m} Tc-pertechnetate.....	<input type="checkbox"/>					
All Thyroid uptakes		<input type="checkbox"/>					
Thyroid uptake	¹³¹ I-sodium iodide.....	<input type="checkbox"/>					
	¹²³ I-sodium iodide.....	<input type="checkbox"/>					
All Liver scans		<input type="checkbox"/>					
Liver scan	¹⁹⁸ Au-Colloid	<input type="checkbox"/>					
	^{99m} Tc -SC.....	<input type="checkbox"/>					
All Brain scans		<input type="checkbox"/>					
Brain scan	¹³¹ ISHA.....	<input type="checkbox"/>					
	¹⁹⁷ Hg-, ²⁰³ Hg-chlormerodrin	<input type="checkbox"/>					
	^{99m} Tc (pertechnetate, DTPA, HMPAO, etc.)	<input type="checkbox"/>					
All Renal scans		<input type="checkbox"/>					
Renal scan	¹⁹⁷ Hg-, ²⁰³ Hg-chlormerodrin	<input type="checkbox"/>					
	¹³¹ I-hippurate.....	<input type="checkbox"/>					
	^{99m} Tc (DTPA, MAG3, DMSA, etc.).....	<input type="checkbox"/>					
All Bone scans		<input type="checkbox"/>					
Bone scan	⁸⁵ Sr-chloride.....	<input type="checkbox"/>					
	^{99m} Tc (phosphate, MDP, etc.)	<input type="checkbox"/>					
All Lung perfusion scans		<input type="checkbox"/>					
Lung perfusion scan	¹³¹ I-MAA.....	<input type="checkbox"/>					
	^{99m} Tc (MAA, HAMicrospheres, etc.).....	<input type="checkbox"/>					

DIAGNOSTIC PROCEDURE, cont.	RADIOPHARMACEUTICAL	NEVER	How many TIMES per WEEK did you perform these procedures in each time period?				
			1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
All Lung ventilations		<input type="checkbox"/>					
Lung ventilation ¹³³ Xe.....		<input type="checkbox"/>					
^{99m} Tc-DTPA (aerosol)		<input type="checkbox"/>					
All Bone marrow scans		<input type="checkbox"/>					
Bone marrow scan ¹⁹⁸ Au-Colloid		<input type="checkbox"/>					
^{99m} Tc-SC.....		<input type="checkbox"/>					
All Gallbladder scans with ^{99m}Tc (HIDA, DISIDA, etc.)		<input type="checkbox"/>					
All GI bleeding scans with ^{99m}Tc (labeled RBC, pertechnetate, SC, etc.)		<input type="checkbox"/>					
All Cardiac scans		<input type="checkbox"/>					
Cardiac scan ²⁰¹ Tl-chloride		<input type="checkbox"/>					
^{99m} Tc-MIBI (1 day).....		<input type="checkbox"/>					
^{99m} Tc-MIBI (2 day).....		<input type="checkbox"/>					
^{99m} Tc (labeled RBC, phosphate, etc.).....		<input type="checkbox"/>					
All Tumor and abscess localizations		<input type="checkbox"/>					
Tumor and abscess localization ⁶⁷ Ga-citrate		<input type="checkbox"/>					
¹¹¹ In (pentreotide, WBC, etc.).....		<input type="checkbox"/>					
All Pancreas scans		<input type="checkbox"/>					
All PET scans (Brain) with ¹⁸F-FDG		<input type="checkbox"/>					
All PET scans (except brain)		<input type="checkbox"/>					
PET scan (except brain) ¹⁸ F-FDG.....		<input type="checkbox"/>					
⁸² Rb-chloride		<input type="checkbox"/>					

Please list other DIAGNOSTIC RADIOISOTOPE procedures below:		How many TIMES per WEEK did you perform these procedures in each time period?				
DIAGNOSTIC PROCEDURE	RADIOPHARMACEUTICAL	1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
1. <input type="text"/>	<input type="text"/>					
2. <input type="text"/>	<input type="text"/>					
3. <input type="text"/>	<input type="text"/>					

The following questions are about your work patterns and practices while performing or assisting with **DIAGNOSTIC RADIOISOTOPE** procedures. Please complete all questions for each time period.

	1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
<p>6a. Did you ever prepare radiopharmaceuticals for DIAGNOSTIC procedures? Do NOT include if prepared by a radiopharmacy. <input type="checkbox"/> Never If NEVER, go to Question 7a.</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>6b. How many TIMES per WEEK did you prepare radiopharmaceuticals?</p>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<p>6c. When you prepared radiopharmaceuticals, did you use any radiation protection? <input type="checkbox"/> Never If NEVER, go to Question 7a.</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>6d. Check all of the following that you typically used more than 50% of the time while preparing radiopharmaceuticals:</p>					
lead shielded vial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lead shielded syringe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lead apron	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fume hood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L-Block, L-shield or lead L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
<p>7a. Did you ever elute the ^{99m}Tc generator? <input type="checkbox"/> Never If NEVER, go to Question 8a.</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>7b. How many TIMES per WEEK did you elute the ^{99m}Tc generator?</p>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<p>7c. When you eluted the ^{99m}Tc generator, did you use any radiation protection? <input type="checkbox"/> Never If NEVER, go to Question 8a.</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>7d. Check all of the following that you typically used more than 50% of the time while eluting the ^{99m}Tc generator:</p>					
lead shielded vial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lead apron	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fume hood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8a. Did you ever inject patients with a **DIAGNOSTIC RADIOISOTOPE**? **Never**

If NEVER, go to Question 9a.

	1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8b. How many **TIMES** per **WEEK** did you inject patients with a radioisotope?

8c. When you injected patients, did you use any radiation protection? **Never**

If NEVER, go to Question 9a.

8d. Check all of the following that you typically used more than 50% of the time while injecting patients:

- lead shielded syringe
- lead apron
- other (specify) _____ ...

9a. When you assisted patients for **DIAGNOSTIC RADIOISOTOPE** examinations, did you use any radiation protection? **Never**

If NEVER, go to Question 10a.

	1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9b. Check all of the following that you typically used or did more than 50% of the time while assisting patients:

- lead apron
- moved more than 3 feet away from patient.....
- other (specify) _____ ...

10a. When you imaged patients, did you use any radiation protection? **Never**

If NEVER, go to Question 11a.

	1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10b. Check all of the following that you typically used or did more than 50% of the time while imaging patients:

- lead apron
- moved more than 3 feet away from patient.....
- other (specify) _____ ...



SECTION 2: THERAPEUTIC RADIOISOTOPE PROCEDURES

11. Did you ever perform or assist with THERAPEUTIC RADIOISOTOPE procedures at least once a MONTH for a year or more?

NO → STOP (Thank you. Please return survey.)

YES (Please continue.)

12. What years did you FIRST and LAST perform or assist with THERAPEUTIC RADIOISOTOPE procedures at least once a MONTH?

--	--	--	--

FIRST YEAR

--	--	--	--

LAST YEAR (Enter current year if still working with procedures.)

13. During each time period, how many YEARS did you perform or assist with THERAPEUTIC RADIOISOTOPE procedures at least once a month?

Number of YEARS				
1945-1964	1965-1979	1980-1989	1990-1999	2000-2009

14. During each time period, how many total TIMES per MONTH did you usually perform or assist with THERAPEUTIC RADIOISOTOPE procedures?

Total Number of TIMES per MONTH				
1945-1964	1965-1979	1980-1989	1990-1999	2000-2009

15. For the following THERAPEUTIC RADIOISOTOPE procedures, please provide your best estimate of how many TIMES per MONTH you performed or assisted with these procedures, with the specific radionuclide listed, during each time period. If you used more than one radionuclide for a given procedure, please include in the section below.

NOTE: Leave all time period boxes blank if you NEVER worked with a procedure; leave specific time period boxes blank if you worked with a procedure less than once a month during that time period.

THERAPEUTIC PROCEDURE OR DISEASE	RADIONUCLIDE	NEVER	How many TIMES per MONTH did you perform these procedures in each time period?				
			1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
Hyperthyroidism	¹³¹ I 	<input type="checkbox"/>					
Thyroid cancer	¹³¹ I 	<input type="checkbox"/>					
Thyroid ablation	¹³¹ I 	<input type="checkbox"/>					
Follow up after thyroid ablation.....	¹³¹ I 	<input type="checkbox"/>					
Malignant effusion	¹⁹⁸ Au-Colloid.....	<input type="checkbox"/>					
Bone metastases	¹⁵³ Sm	<input type="checkbox"/>					
Non-Hodgkin's lymphoma or liver tumor	⁹⁰ Y	<input type="checkbox"/>					

Please list other THERAPEUTIC RADIOISOTOPE procedures or disease below:

	THERAPEUTIC PROCEDURE	RADIONUCLIDE	How many TIMES per MONTH did you perform these procedures in each time period?				
			1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
1.							
2.							
3.							

The following questions are about your work patterns and practices while performing or assisting with THERAPEUTIC RADIOISOTOPE procedures. Please complete all questions for each time period.

	1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
16a. Did you ever prepare radiopharmaceuticals for THERAPEUTIC procedures? Do NOT include if prepared by a radiopharmacy. <input type="checkbox"/> Never If NEVER, go to Question 17a.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
16b. How many TIMES per MONTH did you prepare radiopharmaceuticals?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
16c. When you prepared radiopharmaceuticals, did you use any radiation protection? <input type="checkbox"/> Never If NEVER, go to Question 17a.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
16d. Check all of the following that you typically used more than 50% of the time while preparing radiopharmaceuticals: lead shielded vial <input type="checkbox"/> lead shielded syringe <input type="checkbox"/> lead apron <input type="checkbox"/> fume hood <input type="checkbox"/> L-Block, L-shield or lead L <input type="checkbox"/> other (specify) _____ <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

	1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
17a. Did you ever administer oral ¹³¹I? <input type="checkbox"/> Never If NEVER, go to Question 18a.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
17b. How many TIMES per MONTH did you administer oral ¹³¹I?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
17c. When you administered oral ¹³¹I, did you use any radiation protection? <input type="checkbox"/> Never If NEVER, go to Question 18a.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
17d. Check all of the following that you typically used more than 50% of the time while administering oral ¹³¹I: lead apron <input type="checkbox"/> other (specify) _____ <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>



	1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
18a. Did you ever inject patients with a THERAPEUTIC RADIOISOTOPE? <input type="checkbox"/> Never If NEVER, go to Question 19a.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
18b. How many TIMES per MONTH did you inject patients with the radioisotope?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
18c. When you injected patients with the radioisotope, did you use any radiation protection? <input type="checkbox"/> Never If NEVER, go to Question 19a.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
18d. Check all of the following that you typically used more than 50% of the time while injecting patients: lead apron lead shielded syringe other (specify) _____ ...	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

	1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
19a. When you assisted patients for THERAPEUTIC RADIOISOTOPE procedures, did you use any radiation protection? <input type="checkbox"/> Never If NEVER, end of survey. Thank you.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
19b. Check all of the following that you typically used or did more than 50% of the time while assisting patients: lead apron moved more than 3 feet away from patient..... other (specify) _____ ..	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Thank you!