(Form 5)

Accession Number

**Notice of Change for the Resident Researcher of the Joint Usage/Research for Research Center for Radiation Disaster Medical Science**

　　　　　　　　　　　　　　　　　　　Date (year/month/date): 　　　/　　　/

　To: Director of Research Center for Radiation Disaster Medical Science

　　　　　　　　　　　　　Applicant

　　　　　　　　　　　　　Representative’s Name:

　　　　　　　　　　　　　Affiliated Organization:

　　　　　　　　　　　　　Affiliated Department:

　Joint Research Title:

　Regarding this joint research subject, I hereby change the resident researcher(s) as follows:

* Before change

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Affiliated Organization | Affiliated Department | Job Title |
|  |  |  |  |

* After change

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Affiliated Organization | Affiliated Department | Job Title |
|  |  |  |  |