

Please forward one week before exposure request, to _____ (Tel. 225-578-460), located at CAMD/LSU, 6980 Jefferson Highway, 70806, Room 10 . The samples should accompany the routing sheet or be deposited at the facility, in the "User Box".

_____ : _____

Sample Name: _____

Resist Type: _____ Resist Thickness: _____ (m)

Substrate Material: _____ Size: _____ (cm)

Mask Name: _____ Mask Format: _____

Mask Membrane Material and Thickness: _____ (m)

Thickness of SU-8 Layer remaining on the mask: _____ (m)

Ring Energy: _____ (Gev) Beamline: _____

Filter Material and Thickness: _____ (m) He Pressure: _____ (torr)

Proximity Gap: _____ (m)

Min. Bottom Dose: _____ (J/cm³) Max. Ratio of Top to Bottom Dose: _____

Scan Length: _____ (cm or inch) Aperture required: _____ (cm)

Dose per cm: _____ (mA.min/cm) Total Dose: _____ (mA.min)

Cooling required: mask & substrate mask only no cooling

Exposure will be performed by user Yes No

Date received at CAMD: _____ Approved by: _____