

EXPOSURE REQUEST FORM

Please forward one week before exposure request, to Craig Stevens (Tel. 225-578-4603), located at CAMD/LSU, 6980 Jefferson Highway, 70806, Room 106. The samples should accompany the routing sheet or be deposited at the facility, in the "User Box".

Project Reference Number (PRN): _____

Contact Person: _____ **Phone:** _____ **E-mail:** _____

SAMPLE DESCRIPTION AND EXPOSURE PARAMETERS

Sample Name: _____

Resist Type: _____ Resist Thickness: _____ (μm)

Substrate Material: _____ Size: _____ (cm)

Mask Name: _____ Mask Format: _____

Mask Membrane Material and Thickness: _____ (μm)

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

Ring Energy: _____ (Gev) Beamline: _____

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

Proximity Gap: _____ (μm)

Min. Bottom Dose: _____ (J/cm^3) Max. Ratio of Top to Bottom Dose: _____

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

Dose per cm: _____ ($\text{mA}\cdot\text{min}/\text{cm}$) Total Dose: _____ ($\text{mA}\cdot\text{min}$)

Cooling required: mask & substrate mask only no cooling

Exposure will be performed by user Yes No

CAMD OFFICE USE ONLY

Date received at CAMD: _____ Approved by: _____

Anticipated exposure date at CAMD: _____

Exposure performed at CAMD by: _____ at _____ Beamline on Date: _____

Date notified to pick up: _____ Date picked up: _____ by: _____