December 12, 2001

Mr. J. William Lessig
Plant Manager
Honeywell Specialty Chemicals
P.O. Box 430
Metropolis, IL 62690

SUBJECT: NRC INSPECTION REPORT 04003392/2001-006(DNMS) - HONEYWELL AND NOTICE OF VIOLATION

Dear Mr. Lessig:

On November 29, 2001, the NRC concluded a routine inspection at your Metropolis, Illinois facility. The purpose of the inspection was to determine whether activities authorized by the license were conducted safely and in accordance with NRC requirements. At the conclusion of the inspection, the preliminary findings identified in the enclosed report were discussed with you and members of your staff.

Areas examined during the inspection are identified in the report. Within these areas, the inspection consisted of a selective examination of procedures and representative records, interviews with personnel, and observations of activities in progress. Based on the results of the inspection, the NRC has determined that a violation of NRC requirements occurred.

The violation is cited in the enclosed Notice of Violation (Notice) and the circumstances surrounding the violation are described in the enclosed report. The violation was cited for the failure to perform a “Request for Process Modification” (PT-101) for the installation and use of two temporary standby diesel generators.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. The NRC will use your response, in part, to determine whether further enforcement action is necessary to ensure compliance with regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures will be available **electronically** for public inspection in the NRC Public Document Room **or** from the *Publicly Available Records (PARS) component of NRC's document system (ADAMS)*. *ADAMS is accessible from* the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

We will gladly discuss any questions you have concerning this inspection.

Sincerely,

/RA by M. Phillips acting for/

Patrick L. Hiland, Chief
Fuel Cycle Branch

Docket No. 04003392
License No. SUB-526

Enclosures: 1. Notice of Violation
2. Inspection Report 04003392/2001-006(DNMS)

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NOTICE OF VIOLATION

Honeywell Specialty Chemicals
Metropolis, Illinois

Docket No. 04003392
License No. SUB-526

During an NRC inspection conducted November 5 through 29, 2001, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) NUREG-1600, December 18, 2000, the violation is listed below:

> License Condition 10 of Source Materials License SUB-526, Amendment 14, authorized in part, the use of licensed materials in accordance with the statements, representations, and conditions in Chapter 1 through 7 of the license application.
>
> Chapter 5, Section 5.4 of the license, “Chemical Safety Plan,” required, in part, that plant operations comply with the Chemical Safety Plan as described in Chapter 13.4 of the license application. Chapter 13, Section 13.4.9, “Management of Change,” stated that plant policy PT-1, “Process Modification Procedure,” outlined the basis, criteria, and authorization needed for effecting a change. Plant policy PT-1 required that the process modification procedure, PT-101, be implemented for changes to the plant that required additional training for production personnel or to plant-related occupational health equipment. The standby diesel generator was a piece of equipment provided for safe and orderly shutdown of the process equipment to maintain the process in a safe condition.
>
> Contrary to the above, between May 3, 2001 and September 19, 2001, the licensee failed to implement its management of change procedures, PT-101, for the temporary standby diesel generator replacements.
>
> **This is a Severity Level IV violation (Supplement VI). (VIO 04003392/2001-006-01)**

Pursuant to the provisions of 10 CFR 2.201, Honeywell Specialty Chemicals, is hereby required to submit a written statement or explanation to the U. S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555, with a copy to the Regional Administrator, Region III, 801 Warrenville Road, Lisle, Illinois 60532-4351, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for the violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation; (2) the corrective steps that have been taken and the results achieved; (3) the corrective steps that will be taken to avoid further violations; and (4) the date when full compliance will be achieved. Your Notice of Violation response may reference or include previously docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an Order or Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

If you contest this enforcement action, you should also provide a copy of your response to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555-0001.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. If personal privacy or proprietary information is necessary to provide an acceptable response, then please provide a bracketed copy of your response that identifies the information that should be protected and a redacted copy of your response that deletes such information. If you request withholding of such material, you must specifically identify the portions of your response that you seek to have withheld and provide in detail the bases for your claim of withholding (for example, explain why the disclosure of information will create an unwarranted invasion of personal privacy, or provide the information required by 10 CFR 2.790(b) to support a request for withholding confidential commercial or financial information). If safeguards information is necessary to provide an acceptable response, please provide the level of protection described in 10 CFR 73.21.

In accordance with 10 CFR 19.11, you may be required to post this Notice within two working days.

Dated this 12th day of December 2001.

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No:	04003392
License No:	SUB-526
Report No:	04003392/2001-006(DNMS)
Licensee:	Honeywell Specialty Chemicals
Facility:	Metropolis Works
Location:	P. O. Box 430 Metropolis, IL 62960
Dates:	November 5 through 29, 2001
Inspector:	Mary Lynne Thomas, Paducah Resident Inspector
Approved By:	Patrick Hiland, Chief Fuel Cycle Branch Division of Nuclear Materials Safety

EXECUTIVE SUMMARY

Honeywell Specialty Chemicals
NRC Inspection Report 040-03392/2001-006(DNMS)

Operations

- Operations were conducted in accordance with the applicable procedures for the specific tasks being performed. Operators were knowledgeable of safe operating parameters for cognizant equipment. Housekeeping was poor, but plant management took immediate action to reduce foreign material in operations areas. (Section O1.1)

Maintenance and Surveillance

- The inspector reviewed the license and the licensee's procedure and determined that there was no Post Maintenance Testing program required, nor was one in place. Preventive maintenance for critical equipment that was reviewed by the inspector was performed when scheduled. Areas where hot work was being performed were free of combustible material, fire protection equipment was readily available, and the hot work permits were posted. Housekeeping in other areas was poor. (Section M1.1)

Radiation Protection

- The licensee was adequately implementing a respiratory protection program. However, the inspector identified two weaknesses. These weaknesses involved inventory and control of respirators and written procedures for the respiratory program. Licensee staff appeared to be trained and cognizant of respiratory protection requirements. (Section RP1.1)

- The inspector determined that the licensee is adequately implementing its radiation protection program. (Section RP1.2)

Plant Support

- The inspector noted that the facility's process modification procedure was not implemented prior to installation of either temporary standby generator. The NRC inspector reviewed the issue, and identified a violation of section 13.4.9 of the license, "Management of Change." (Section P2.1)

Training

- The inspector reviewed the license and determined that license condition 13.4.7.1.5, "Maintaining Employee Training Records," addressed plans for implementing a centralized database by the end of 1996. The inspector concluded that the failure to implement this centralized database, administered by the training department, was a weakness. (Section T1.1)

Report Details

I. Operations

O1 Conduct of Operations

O1.1 Conduct of Operations

a. Inspection Scope (TI2600/003)

The inspector observed general operations in the Feed Materials Building (FMB) and other areas onsite to verify that the activities were performed safely and in accordance with applicable license conditions and regulatory requirements. In particular, the inspector observed the following activities:

- FMB and control room operations
- Routine operator rounds of the FMB

b. Observations and Findings

The inspector noted that the activities observed were conducted in accordance with applicable procedures and postings, and that operators used appropriate protective clothing and equipment. The FMB units (ore preparation, reduction, green salt, fluorination, and distillation) were all in operation during the inspection. Control room operations were conducted with attention focused on equipment important to safety. Operation log books were current for activities conducted during the shifts observed.

The inspector observed the green salt assistant operator perform routine rounds. The operator noted a discrepancy between the actual temperature of a uranium tetrafluoride (UF_4) filter heater and its expected value. The operator noted this discrepancy on the rounds sheet and subsequently adjusted the temperature to its expected value. In addition, the inspector observed the ore preparation assistant operator perform routine rounds. Both operators appeared knowledgeable of the equipment and its operating parameters.

The inspector discussed ongoing operation activities and the status of equipment with control room operators in the FMB at each of the control stations (ore prep/reduction, green salt, fluorination, and distillation). The inspector observed that operational alarms were promptly addressed, and only a few standing alarms existed. In each case when a standing alarm was noted, the operators initiated appropriate compensatory actions.

During facility tours, the inspector observed housekeeping practices. The inspector found several tools, both broken and useable, and personal protective equipment laying about the FMB. Both maintenance and operation have their own special work permit (SWP) system with a box entitled “Work Completed, Area Cleaned, Permit Returned.” These SWPs were being signed off without ensuring that the area was cleaned. The inspector considered this to be a weakness in both operations and maintenance. The plant manager directed the evening maintenance crew to perform housekeeping duties in the FMB.

c. Conclusions

Operational activities observed were conducted in accordance with the applicable procedures. Operators were knowledgeable of safe operating parameters for cognizant equipment. Housekeeping was poor, but plant management took immediate actions to reduce foreign materials in operations areas.

O1.2 (Closed) IFI 04003392/2001-005-01 - Review of plant staff implementation of corrective actions to a uranium hexafluoride release: The licensee took the following corrective actions to address the uranium hexafluoride release which occurred on August 10, 2001:

- Operations procedure 10.3, "Washing Low Boiler Condenser" was revised at step 10.3.2.2 to bleed the pressure off the system by the installation of a ball valve on the blind flange used to perform the pressure check, and at step 10.3.2.15 to require the use of a valve wrench by the operator to close the effected valve completely.

- The licensee held training on these changes during the last week of October and the first week of November.

The licensee's analysis of the release indicated that two block valves were not fully seated nor was there a means to verify that UF_6 lines were not under pressure prior to opening the system. The details of the release are discussed in inspection report 2001-005, section P1.1. This item is closed.

II. Maintenance and Surveillance

M1.1 Conduct of Maintenance and Surveillance

a. Inspection Scope (88025)

The inspector discussed the maintenance program with cognizant staff. In addition, the inspector toured several process buildings to observe the conditions of areas where hot work was being performed. The inspector also reviewed the following procedures:

- QA During Equipment Installation, #228
- Reliability Investigation Request, #173
- Balancing Procedure, #137
- Procedure for Implementing the Protective Maintenance Program, #232
- Bolt Torque, #189, Revision 1
- Work Authorization Procedure, #226
- Critical equipment preventive maintenance list

b. Observations and Findings

The inspector reviewed several maintenance procedures to determine if they contained requirements for operations personnel to approve or control maintenance activities within process areas. The inspector questioned the cognizant staff and determined that both Operations and Maintenance have Special Work Permits on which Operations signed off that the work could be performed prior to the work being initiated. The inspector also questioned the staff regarding post maintenance testing (PMT) and determined that the licensee did not have a PMT program. Equipment was returned to

service by Operations, should the equipment not function or operate as required, Operations contacted Maintenance for Maintenance to rework the job. The inspector observed this practice on November 8, 2001, while observing the green salt assistant operator perform his routine rounds. During this time an unplanned uranium release occurred inside the FMB on the "B" UF_4 Elevator Primary Discharge Screw. The inspector then questioned the shift supervisor and determined that this equipment had maintenance performed on it over the weekend of November 3-4, 2001. The cause of the unplanned uranium release was that the Discharge Screw cover had not been properly tightened down after maintenance was complete. The licensee informed the inspector that failure to perform a PMT resulted in the unplanned uranium release. The inspector considered the failure to perform a PMT a weakness. The inspector reviewed the license and the licensee's procedure and determined that PMT was not required to be performed.

The inspector toured areas where hot work was being performed and observed that the areas were posted with a hot work permit, fire protection equipment was readily available, and the areas were free of combustible material. The inspector observed housekeeping in other areas and determined it to be poor. This issue is discussed in section O1.1.

The inspector reviewed the critical equipment preventative maintenance list for the previous month to determine if the equipment listed had been tested, inspected, or had its preventative maintenance performed by its scheduled due date and in accordance with the respective procedures. Specifically, the inspector reviewed the records for cylinder buggies, cylinder fill spot recorder number 1, and the test of the shutdown switch for green salt. No discrepancies were found.

c. Conclusions

The inspector reviewed the license and the licensee's procedure and determined that PMT was not required to be performed. Preventive maintenance for critical equipment that was reviewed by the inspector was performed when scheduled. Areas where hot work was being performed were free of combustible material, fire protection equipment was readily available, and the hot work permits were posted. Housekeeping in other areas was poor.

III. Radiation Protection

RP1.1 Respiratory Protection Program

a. Inspection Scope (83822)

The inspector reviewed the following aspects of the respiratory protection program:

- Fit testing and training of respirator users
- Storage of respirators
- Inventory and control of respirators

The inspector also discussed the use of respirators with plant staff.

b. Observations and Findings

The inspector reviewed fit-testing and training of respirator users. A review of fit-testing records showed that no one was overdue for fit-testing. Each record contained the model and size of respirator for the user. The user was issued a card with that information. The inspector discussed respiratory protection with operators who appeared cognizant of issues related to the proper use of respirators.

The inspector observed the respirator storage location and noted that the respirators were each in a plastic bag, placed in large bins, and that the fully extended face piece straps were flipped around the front of the face piece. The inspector discussed the storage of respirators with the Health Physics (HP) Supervisor. The HP Supervisor was not cognizant of storage requirements by the manufacturer. The HP Supervisor contacted the manufacturer. In addition, the inspector found several respirators laying about the facility. One full face respirator with canister attached was found hanging on a coat rack by the Production supervisor's office. The canister had a three-year shelf-life expiration date of May 1999. The inspector determined this to be a weakness in the inventory and control of the respiratory protection program.

The inspector reviewed the licensee's written procedures for their respiratory protection program with respect to the requirements in 10 CFR 20.1703(c)(4). The inspector noted that the licensee had implemented the written procedure required by 10 CFR 20.1703(c)(4)(ix) with a one page policy memorandum. The inspector determined this to be a weakness in the written procedures for the respiratory protection program.

c. Conclusions

The licensee was adequately implementing a respiratory protection program. However, the inspector identified two weaknesses. These weaknesses involved inventory and control of respirators and written procedures for the respiratory program. Licensee staff were trained and cognizant of respiratory protection requirements.

RP1.2 Radiation Protection

a. Inspection Scope (83822)

The inspector reviewed the following aspect of the licensee's radiation protection program:

- External dosimetry records for the prior year
- National Voluntary Laboratory Accreditation Program (NVLAP) accredited dosimetry
- Declared Pregnant Worker Exposure
- Occupational Exposure of Minors
- Planned Special Exposures
- Posting and Labeling
- Environmental Dosimetry
- Exposure Control

The inspector discussed these aspects with the Health Physics Specialist.

b. Observations and Findings

The inspector reviewed the external dosimetry records for the prior year and noted that no one exceeded the 5 rem occupational limit stated in 10 CFR 20.1201. The inspector also verified that the licensee was using NVLAP accredited external dosimetry in accordance with 10 CFR 20.1501. The inspector determined through discussions with the Health Physics (HP) Specialist that there had been one declared pregnant worker (DPW) during the prior year. The occupational dose for this DPW during the gestation period was zero rem. The inspector also verified that there were no minors employed at the plant, thus there was no occupational exposure of minors. The inspector discussed planned special exposures (PSE) with the HP Specialist and determined that no PSEs occurred in the prior year. The inspector verified that posting and labeling was adequate and in accordance with 10 CFR 20.1902. The inspector verified that environmental dosimeters were in place at the fenceline and that doses were consistent with the public limit of 2 mrem per hour in an unrestricted area requirement of 10 CFR 20.1301(a)(2) and demonstrated by 10 CFR 20.1302(b)(2)(ii).

The inspector discussed exposure control with the Safety Manager, the HP Supervisor, the HP Specialist, and a shift supervisor in terms of the location and use of the 5th floor showers in the Feed Materials Building. If an employee had been contaminated then the practice described in section 3.2.1 of the license, "Restricted Area - Access Control," was used—an employee would proceed to the shower provided in the UF_6 facility for decontamination and would change into clean coveralls. The employee then would proceed to the regular shower and locker room to change in the normal manner at the end of his shift. However, the normal practice was to don a double set of coveralls whenever the likelihood for contamination was high for a given job; at the end of the job doff the outer set of coveralls at the jobsite and then proceed to either the 5th floor shower in the FMB as stated in the license or the shower in the locker room of the Administration Building.

c. Conclusions

The inspector determined that the licensee was adequately implementing its radiation protection program.

IV. Plant Support

P2 Status of Emergency Preparedness Facilities, Equipment, and Resources

P2.1 (Closed) URI 04003392/2001-005-03 - Installation of Temporary Standby Generator: During the previous inspection, 04003392/2001-005, an inspector noted that in May 2001 the standby diesel generator was removed from service and a temporary generator was installed. The function of the standby generator was to automatically start in the event that normal electrical power was interrupted. Standby power would then be manually distributed to vital loads, as required, including emergency exit lighting in process buildings, and critical instrumentation in the Feed Material Building to monitor the in-process UF_6 and to evacuate equipment as needed to maintain the process in a safe condition.

During the current inspection the inspector reviewed the correspondence submitted by the licensee, the Emergency Generator Operating Log, the licensee's incident investigation report #21332, and PT-101s, "Request for Process Modification" that were prepared as a result of the Unresolved Item.

In the licensee's first letter, dated September 14, 2001, the licensee concluded that the first temporary generator was a "replacement-in-kind" and therefore not subject to Policy No. PT-1, "Process Modification Procedure." The procedure outlined the basis, criteria, and authorization needed for implementing a process change. The procedure defined a process modification as a change to plant-related Occupational Health and Health Physics equipment.

In the licensee's second letter, dated September 21, 2001, the licensee maintained their original conclusion. They added that a second temporary generator was installed on July 18, 2001, which did not have a manual start function. The fact that the second temporary generator was not a "replacement-in-kind" was reported to the NRC on September 19, 2001, Event Report Number 38296. During the licensee's investigation on September 19, 2001, the powerhouse operators stated that they did not believe that run-time logs had to be taken on the temporary generator.

In the licensee's letter, dated October 15, 2001, they stated the corrective actions that were taken as a result of the September 19, 2001 event. These corrective actions included the generation of PT-101s for the second temporary generator. The first of these PT-101s was to fulfill operations training for starting the generator if it failed in the automatic position, the second PT-101 was to install, amend procedures, and perform personnel training for the new permanently installed generator. According to the licensee's policy the first PT-101 was to have been completed prior to installation of the second temporary generator. The inspector determined that a PT-101 should have been completed prior to installation of the first temporary generator as the powerhouse operators failed to take the required run-time logs. If a PT-101 had been generated the licensee would have assessed the need for training on the temporary generators.

License Condition 10 of Source Materials License SUB-526, Amendment 14, authorized, in part, the use of licensed materials in accordance with the statements, representations, and conditions in Chapter 1 through 7 of the license application. Chapter 5, Section 5.4, "Chemical Safety Plan," required, in part, that plant operations comply with the Chemical Safety Plan as described in Chapter 13.4 of the license application. Chapter 13, Section 13.4.9, "Management of Change," stated that plant policy PT-1, "Process Modification Procedure," outlined the basis, criteria, and authorization needed for effecting a change. PT-1 stated that process modifications must be reviewed and approved by all specified approvers before implementation.

Contrary to the above, between May 3, 2001 and September 19, 2001, the licensee failed to implement its management of change procedure, PT-101, for the temporary standby diesel generator replacements.

This **Unresolved Item is closed to a violation (VIO 04003392/2001-006-001)**

c. Conclusions

The inspector noted that the facility's process modification procedure was not implemented prior to installation of either temporary standby generator. The NRC inspector reviewed the issue, and identified a violation of section 13.4.9 of the license, "Management of Change."

P6 Emergency Preparedness Organization and Administration

P6.1 (Discussed) IFI 04003392/2001-005-02 - Implementation of plant-wide database to track action items: The inspector discussed this inspector followup item (IFI) with the Health Physics Supervisor and the Regulatory Affairs Manager. The previous inspection report, 2001005 identified this as a weakness in the documentation of action items and associated corrective actions. The regulatory affairs manager stated that they had not implemented a plant-wide database because their corporate office was evaluating software to perform this same function and that each plant would be required to purchase this software. This IFI will remain open as a result of this discussion.

V. Training

T1.1 Review of Training

a. Inspection Scope (88010)

The inspector reviewed the license condition 13.4.7.1.5, "Maintaining Employee Training Records" and the system currently in use by the licensee. The inspector also reviewed the training records of select employees with respect to initial and refresher training, monthly "B" Safety Council meetings, and the annual health physics quiz.

b. Observations and Findings

The inspector compared the training recordkeeping database and license requirement for such a database. While the inspector did not find any problems with the training personnel, the recordkeeping database was not centralized as planned for in license condition 13.4.7.1.5. As such, it was difficult to locate all of the training records for a given employee. The Training Coordinator stated that records were only entered into the database if they were given to him. Otherwise, each department was keeping its own records either on paper or in separate databases.

The inspector reviewed the training records of select employees. The inspector identified that two employees had missed several "B" Safety Council meetings. License condition 2.5, "Training," required that all experienced employees were re-instructed in safety hazards and proper radiation protection procedures at monthly "B" Safety Council meetings. Following the recent hire of a new Safety Manager, make-up monthly "B" Safety Council meetings will be held to ensure that all employees attend. The failure of the two employees to attend the "B" Safety Council meetings is a violation of License Condition 2.5. However, given the nature of the violation and the immediate corrective actions implemented to correct this minor violation, the inspector determined that this violation of minor safety significance is not subject to formal enforcement action.

The review of one employee's training record printed from the database maintained by the Training Coordinator indicated that this employee had not taken the annual health physics quiz. The health physics quiz records were maintained in a separate database by the HP Technician Supervisor. The inspector's review of the HP database indicated that the employee had taken the annual quiz at a later date than the rest of the employees. This record was not turned over to the Training Coordinator for entry into the plant's training record database.

The other records reviewed indicated that each employee had the initial safety training and was current with respect to job specific refresher training, "B" Safety Council meetings, and the annual health physics quiz.

Refresher training was administered by each department. A weekly list was generated by the Operations department for operations personnel indicating the schedule for refresher training.

The inspector discussed training with several operators and supervisors. All were cognizant of their training requirements.

c. Conclusions

The inspector reviewed the license and determined that license condition 13.4.7.1.5, "Maintaining Employee Training Records," addressed plans for implementing a centralized database by the end of 1996. The inspector concluded that the failure to implement this centralized database, administered by the training department, was a weakness.

VI. Management Meeting

X1. Exit Meeting Summary

The inspector presented the inspection results to members of the plant staff and management at the conclusion of the inspection on November 29, 2001. The plant staff acknowledged the findings presented. The inspector asked the plant staff whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Honeywell Specialty Chemicals

N. Rodgers, Health Physics Specialist
* W. Lessig, Plant Manager
* H. Roberts, Health Physics Supervisor
M. Shepherd, Regulatory Affairs Manager
* J. Pratte, Maintenance Manager

Other members of the licensees' staff were also contacted during the inspection.

* Denotes those attending the exit meeting on November 29, 2001.

INSPECTION PROCEDURES USED

IP 83822:	Radiation Protection
IP 88025:	Maintenance
IP 88010:	Training
IP 88020 and TI 2600/003:	Operational Safety Review

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened:

04003392/2001006-01	VIO	Failure to implement PT-101 modification for use of temporary standby diesel generators.

Closed:

04003392/2001-005-03	URI	Installation of temporary standby generator
04003392/2001-005-01	IFI	Review of the plant staff's implementation of corrective actions to a uranium hexafluoride release

Discussed:

04003392/2001-005-02	IFI	Implementation of plant-wide database to track action items

LIST OF ACRONYMS USED

ADAMS	Agencywide Document Access and Management System
CFR	Code of Federal Regulations
DNMS	Division of Nuclear Material Safety
DPW	Declared Pregnant Worker
FMB	Feed Materials Building
HP	Heath Physics
IFI	Inspector Followup Item
IP	Inspection Procedure
NOV	Notice of Violation
NRC	Nuclear Regulatory Commission
NVLAP	National Voluntary Laboratory Accreditation Program
PARS	Publicly Available Records
PDR	Public Document Room
PERR	Public Electronic Reading Room
PMT	Post Maintenance Test
PSE	Planned Special Exposure
SWP	Special Work Permit
UF_4	Uranium Tetrafluoride
UF_6	Uranium Hexafluoride
URI	Unresolved Item
VIO	Violation