

CARDIAC TESTING CENTER, INC

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RECEIVED
REGION 1

'05 JAN 25 P12 :57

REPLY TO A NOTICE OF VIOLATION

United States Nuclear Regulatory Commission
Region 1

475 Allendale Road
King Of Prussia, PA
19406-1415

Attention: Regional Administrator

License No. 29-20960-01

Cc Document Control Desk,
Washington, D.C. 20555
1/6/05

To Whom It May Concern:

This letter is written in response to our notice of violations dated 12/25/04, inspection 03022155/2004001.

Violation A

On May 25th, during a New Jersey State inspection, it was discovered that our crash cart sharps container had detectable radiation. Physicians were contaminating this sharps container by injecting a frequently used crash cart drug through the same intravenous hub as previously injected Tc-99m-Tetrofosmin. This sharps container is not specific in our area survey, since it is used for the administration of crash cart drugs only. Subsequent to their inspection, area monitoring did not include this sharps container, but any time activity was present, it was to be noted in the "comments" section of the survey. Withholding their inspection report for NRC jurisdiction, the State awaited definition/clarification of this "contained" randomly occurring radiation source and to recommend procedure for the lab.

In addition, disposal of these sharps was addressed at length with the NRC. In no way are these containers sent out for disposal with radioactive materials present. Our sharps are stored in the hot lab and disposed biannually through a company, which requires 5-7 working days advanced notice for pickup. Therefore, there was potential for them to be radioactive at the time of disposal.

Since discussing this with the inspector, these crash cart sharps have been labeled with a removable "radioactive material" sticker and are included in the daily survey. If detectable ionizing radiation is present, a rotating sharps must be used to allow decay of the former in the hotlab.

NMSS/RGNI MATERIALS-004

The understanding of the licensee was that this was to be a benchmark incident potentially occurring in other labs, helping to set better guidelines by the NRC. The licensee was the one who addressed the issue to the inspector, not the other way around. I would like reconsideration pertaining to this. We have properly addressed and rectified this potential radiation hazard as per the NRC inspector's recommendations.

Violation B.

Housecleaning had removed from the licensee's sight, during the months cited one particular technologist's ring badge repeatedly, from her desk, only to be found months later. Housecleaning personnel were notified immediately the evening of inspection that they should never touch such items. However, this badge will be stored safely with the other badges. While aware that the badges were absent on monthly reports, the licensee was unaware that this technologist was without the "spare" extremity monitor, until the day of the inspection. She has been reminded along with all CTC personnel that a spare badge must be worn. An estimation of these months by referencing the other extremity readings the prior year will be incorporated into future badge reports. Landauer will incorporate these estimations into this technologist's monthly report. The 10% percent limit annually for technologist has never been exceeded and is carefully monitored by our auditing physicist quarterly.

Violation C.

The authorized user still had privileges with the facility in case his nuclear camera at his newly established nuclear facility needed repair, although he has never made use of them. I spoke with this authorized user on January 13th and he still wishes to remain on our license as an authorized user for his New Jersey Office in case his camera which is located in Staten Island has problems. Information the inspector received was erroneous and based on assumption. See enclosure.

Submitted January 21, 2005


Deborah G. Tormey, B.S., CNMT
Manager, Cardiac Testing Center

PETER M. LENCHUR, MD, PhD, FACC, FSCAI

Cardiovascular Disease, Interventional and Nuclear Cardiology

- Diplomate of the American Board of Internal Medicine, Cardiovascular Disease and Interventional Cardiology
- Diplomate of the Certification Board of Nuclear Cardiology
- Fellow of the American College of Cardiology
- Fellow of the Society for Cardiovascular Angiography and Interventions

January 13, 2005

Deborah Tormey
Cardiac Testing Center
33 Overlook Road, Suite 305A
Summit, NJ 07901

Dear Deborah:

As per our conversation currently I do not own a nuclear facility in NJ although I practice in a New Jersey office. It would be best to remain an authorized user on your nuclear licenses until further notice.

Thank you,



Peter M. Lenchur, MD, PhD, FACC, FSCAI

THE CERTIFICATION BOARD OF NUCLEAR CARDIOLOGY

Incorporated 1996

CERTIFIES THAT

Peter M. Lenchur, MD

HAVING MET THE REQUIREMENTS PRESCRIBED BY THIS BOARD FOR PHYSICIANS RESIDING
IN THE UNITED STATES AND HAVING SATISFACTORILY PASSED THE REQUIRED EXAMINATION,

IS HEREBY DESIGNATED

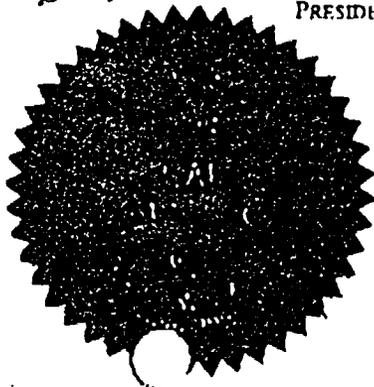
A DIPLOMATE CERTIFIED IN THE SUBSPECIALTY OF

NUCLEAR CARDIOLOGY

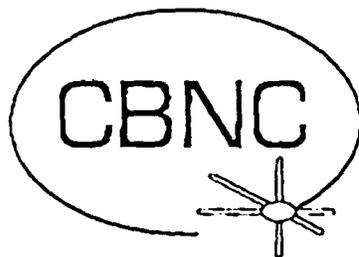
FOR THE PERIOD 2003 THROUGH 2013

Paul D. Cozquin
PRESIDENT

[Signature]
SECRETARY



CERTIFICATE # 2923



OCTOBER 26, 2003