

## ACCEPTANCE REVIEW MEMO

**Licensee:** Castle Medical Center

**License No.:** 53-16929-01

**Docket No.:** 030-11883

**Mail Control No.:** 470792

**Type of Action:** Amend **Date of Requested Action:** 11-28-05

**Reviewer Assigned:** **Date Assigned to Reviewer:** 12-20-05

**Reviewer(s) Who Performed Review:** Gaines

Response Received	Deficiencies Noted During Acceptance Review
	1.
	2.
	3.
	4.

**Reviewer's Initials:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Branch Chief's and/or SR. HP's Initials:** \_\_\_\_\_

**Date:** \_\_\_\_\_

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Action - decommissioning notification should be issued within 30 days.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Termination request < 90 days from date of expiration
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Action to be expedited
<input type="checkbox"/> Medical emergency <input type="checkbox"/> Licensee in noncompliance (i.e. no RSO, location of use/storage not on license, radioactive material in possession not on license) <input type="checkbox"/> National Security <input type="checkbox"/> Other ( _____ )		
<b>Branch Chief's and/or Sr. HP's Initials:</b> _____		<b>Date:</b> _____

<b>SISP Review</b>		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<b>Non-Publicly Available, Sensitive</b> if <u>any</u> item below is checked
<input type="checkbox"/> Radionuclides, forms, and quantities <input type="checkbox"/> Location of RAM <input type="checkbox"/> Building drawings with locations of RAM <input type="checkbox"/> Security of RAM (locks, alarms, etc.) <input type="checkbox"/> SS&D Catalog information <input type="checkbox"/> Specifics of Emergency Plan (routes to and from RAM, response to security events, etc.) <input type="checkbox"/> Safeguards Information		
<b>Branch Chief's and/or Sr. HP's Initials:</b> <u>ADG</u>		<b>Date:</b> <u>12/20/05</u>

ADG

# Castle Medical Center

 **Adventist  
Health**

Administration  
640 Ulukahiki Street  
Kailua, Hawaii 96734-4498  
Tel 808-263-5500  
www.castlemed.org

November 28, 2005

U.S. Nuclear Regulatory Commission, Region IV  
611 Ryan Plaza Drive, Suite 400  
Arlington, TX 76011-8064

Subject: NRC License No.53-16929-01  
Docket No. 030-11883

Dear License Reviewer:

Please remove Mitchell Moy M.D. from our list of authorized users.

Please contact Gamma Corporation at 808-373-7009 if you require additional information.

Sincerely,



John Monge  
Vice-President, Operations  
Castle Medical Center

NOV 03 2005

11 70792

DEC 20 2005

DATE

This is to acknowledge the receipt of your letter/application dated 11-28-05, and to inform you that the initial processing, which includes an administrative review, has been performed.

There were no administrative omissions. Your application will be assigned to a technical reviewer. Please note that the technical review may identify additional omissions or require additional information.

Please provide to this office within 30 days of your receipt of this card:

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The action you requested is normally processed within 90 days.

A copy of your action has been forwarded to our License Fee & Accounts Receivable Branch, who will contact you separately if there is a fee issue involved.

Your action has been assigned Mail Control Number 470792.  
When calling to inquire about this action, please refer to this mail control number.  
You may call me at 817-860-8103.

Sincerely,

*Cecelia Murnahan*

Licensing Assistant

BETWEEN:

License Fee Management Branch, ARM  
and  
Regional Licensing Sections

.....  
: (FOR LFMS USE)  
: INFORMATION FROM LTS  
:-----  
: Program Code: 02120  
: Status Code: 0  
: Fee Category: 7C  
: Exp. Date: 20120630  
: Fee Comments: CODE 21  
: Decom Fin Assur Reqd: N  
:.....

LICENSE FEE TRANSMITTAL

A. REGION

1. APPLICATION ATTACHED CASTLE MEDICAL CTR.

Applicant/Licensee: 20051209  
Received Date: 3011883  
Docket No.: 470792  
Control No.: 53-16929-01  
License No.:  
Action Type: Amendment

2. FEE ATTACHED

Amount: \_\_\_\_\_  
Check No.: \_\_\_\_\_

3. COMMENTS

Signed *[Signature]*  
Date 12/18/05

B. LICENSE FEE MANAGEMENT BRANCH (Check when milestone 03 is entered / \_\_/)

1. Fee Category and Amount: \_\_\_\_\_

2. Correct Fee Paid. Application may be processed for:

Amendment \_\_\_\_\_  
Renewal \_\_\_\_\_  
License \_\_\_\_\_

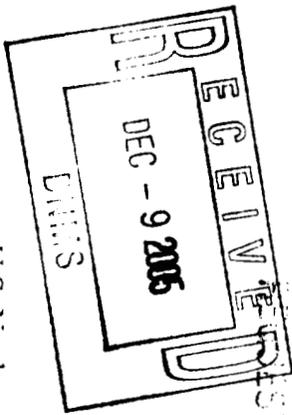
3. OTHER

\_\_\_\_\_  
Signed \_\_\_\_\_  
Date \_\_\_\_\_

**Castle Medical Center**

**Adventist Health**

**Administration**  
640 Ulukani Street  
Kaliua, Hawaii 96734-4489



POSTAL SERVICE  
REGISTERED MAIL

NOV 23 2005



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611 Ryan Plaza Drive, Suite 400  
Arlington, TX 76011-8064

JTLDMP 76011

