Dr. Ahmad Mossavi, M.D.
3200 Sunset Avenue
Ocean, NJ 07712

October 6, 2006

United States Nuclear Regulatory Commission, Region I
475 Allendale Road
King of Prussia, Pennsylvania 19406-1415

Attn: Shirley Xu

Ref: Loss of Rod Source – Cs-137
License Number: 29-30988-01

Dear Ms. Xu:

Based on our telephone conversations with me and my Health Physics Consultant, Mr. Venkata K. Lanka, I am submitting the following the information/corrective actions for your appropriate action(s).

This is to inform you that we lost the following radioactive source which is used to calibrate our Gamma counter.

Description of the licensed material involved:

Radionuclide:	Cesium-137
Quantity:	0.000102 mCi
Chemical Form:	Cesium Chloride
Physical Form:	Rod Source
Source S. No:	BM 0837-010-2
Reference date:	7/6/2005

Description of the circumstances under which the loss or theft occurred:

On June 24, 2006, during the routine quarterly audit conduct by our consultant health physicist Mr. Venkata K. Lanka, we have discovered that we misplaced the above described rod source used for calibrating gamma well counter. We searched every possible place within our nuclear medicine laboratory located at the 20 White Road, Shrewsbury, NJ 07702. We have searched for it in the remainder of our facility. We could not locate it.

Our records indicated that our Nuclear Medicine technologist, Mr. Seth Achamfour-Yeboah, last used the well counter was April 18, 2006. While not in use, Mr. Achamfour-Yeboah stores the rod source in a blue colored leaded container and left the leaded container inside L-block shield.

We have checked with the our radioactive material unit dose delivery company, GE Health Care of NJ, 1 Nylon Place, Livingston, NJ, if the delivery person inadvertently picked up the blue leaded container and found that no delivery person took it by mistake.

A statement of disposition, or probable disposition, of the licensed material involved:

We believe that it may have been disposed into the radioactive waste disposal can along with gloves and/or absorbent papers. Our practice of disposal of waste prior to disposal is that our technologist checks with the Geiger Counter. Mr. Achamfour-Yeboah may have missed this while checking the waste prior to disposal.

Actions that have been taken, or will be taken, to recover the material:

1. We have thoroughly checked our nuclear medicine lab and other labs in my office.
2. Mr. Yeboah, Nuclear Medicine Technologist, checked every other possible place to recover the material.
3. We called the GE Health Care of NJ, 1 Nylon Place, Livingston, NJ, if the delivery person inadvertently picked up the blue leaded container and found that no delivery person took it by mistake.

Actions Taken to Prevent in the Future:

All personal working at our nuclear medicine facility were informed of the incident and educated them of the need for storage of controlled material.

1. Strict instructions were issued for storing all radioactive material in the locked cabinet and not to leave them near to the Gamma Counter or behind the L-block.
2. Since the technologist involved did not pay attention (negligence) to the storage of the above licensed material, I have fired the technologist as of that day.
3. All radioactive sources are kept under lock and key. The new technologist will be informed of the same.
4. On the day of use of radioactive materials on patients in any one of my facilities, I request my technologist to verify that all sources are properly kept under lock and

key. If the technologist finds ant discrepancies, I request the technologist to inform me of the discrepancy immediately to my attention.

Thank you for your assistance and cooperation. Should you have any questions, please do not hesitate to contact me at 732-502-0710.

Sincerely,

Ahmad Mossavi, M.D.