July 31, 2008

U.S. Nuclear Regulatory Commission
Region IV
612 East Lamar Blvd, Suite 400
Arlington, Texas 76011-4125

RE: NRC Inspection Report 030-35770/2008-001 and Notice of Violation

Response to inspection conducted March 26-28, 2008 in Boise, Idaho at PSI,Inc.

The first violation discusses the failure to conduct an annual audit of our radiation protection program. We have conducted audits of our radiation program. The dates of the last two were February 26, 2007 and April 3, 2008. The audit performed in 2007 concerned itself with the program itself in the calendar year 2006 and the 2008 audit looked at records from the 2007 year. The circumstances that led to this violation involved relocating our records from one storage facility to another storage facility. The latter facility's key to its lock was lost and we had to cut the lock before the records could be located. In the future, we will keep the last two years records in the pharmacy, readily available.

The second violation was failure to monitor the occupational dose to the skin of any extremity by supplying personnel monitoring devices to individuals likely to receive a dose in excess of 10 percent of the limit. From the inception of our license to May 2006, we routinely monitored our technician's extremity. An evaluation was performed at that time and it was determined that the actual doses received were far less that 10 percent of the annual limits. In consultation with our consultant, we eliminated the extremity badges

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for those individuals. We will not argue that we did not supply the badges during this time frame. We certainly believe we met the spirit and intent of a badge program by supplying these badges but felt that since the technicians were not receiving doses of a magnitude above or even close to 10 percent of the annual limits, there would be no problem with discontinuing this practice. We immediately ordered monthly right and left finger badges for technicians at the close of our inspection and have been in full compliance since. If the data does not support the need for this badge program, we will reevaluate the results and proceed accordingly.

The third and final violation was failure to obtain calibration of a bioassay assessment instrument by a person authorized by the NRC. The root cause of this violation was a lack of understanding of our license conditions. Specifically, in the NUREG volume #56, page 8-34 it states that equipment calibrations may be performed by the pharmacy or by another person authorized by the NRC. In my experience, self-calibrations of bioassay measurement equipment have been performed by the pharmacy in the pharmacy. We will abide by our license condition of having this equipment calibrated by an outside NRC approved vendor. The equipment has been re-calibrated and full compliance has been achieved.

To summarize, we received three violations of a very minor, severity level IV level. The root cause of the violations have been identified in each instance and comprehensive corrective action has been taken. Full compliance for all three violations has been accomplished. Corrective actions are being taken to avoid these violations to occur a second time.

We with to thank the NRC inspectors who conducted our inspection, Mr. Roberto J. Torres and Mr. Rick Munoz.

Sincerely,

PSI Management.
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Unit #210
Garden City, Idaho 83714