NRC FORM 591M PART 1
(10-2003) 10 CFR 2.201

U.S. NUCLEAR REGULATORY COMMISSION

SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION

1. LICENSEE/LOCATION INSPECTED:	2. NRC/REGIONAL OFFICE
Scott Memorial Hospital 1451 North Gardner Street Scottsburg, Indiana 47170 REPORT NUMBER(S) 2009-001	**Region III** **U.S. Nuclear Regulatory Commission** **2443 Warrenville Road, Suite 210** **Lisle, Illinois 60532-4351**

3. DOCKET NUMBER(S)	4. LICENSEE NUMBER(S)	5. DATE(S) OF INSPECTION
030-33192	13-26500-01	August 27 , 2009

LICENSEE:

The inspection was an examination of the activities conducted under your license as they relate to radiation safety and to compliance with the Nuclear Regulatory Commission (NRC) rules and regulations and the conditions of your license. The inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and observations by the inspector. The inspection findings are as follows:

☒ 1. Based on the inspection findings, no violations were identified.

☐ 2. Previous violation(s) closed.

☐ 3. The violation(s), specifically described to you by the inspector as non-cited violations, are not being cited because they were self-identified, non-repetitive, and corrective action was or is being taken, and the remaining criteria in the NRC Enforcement Policy, NUREG-1600, to exercise discretion, were satisfied.

_____ Non-Cited Violation(s) was/were discussed involving the following requirement(s) and Corrective Action(s):

☐ 4. During this inspection certain of your activities, as described below and/or attached, were in violation of NRC requirements and are being cited. This form is a NOTICE OF VIOLATION, which may be subject to posting in accordance with 10 CFR 19.11.
(Violations and Corrective Actions)

Licensee's Statement of Corrective Actions for Item 4, above.

I hereby state that, within 30 days, the actions described by me to the inspector will be taken to correct the violations identified. This statement of corrective actions is made in accordance with the requirements of 10 CFR 2.201 (corrective steps already taken, corrective steps which will be taken, date when full compliance will be achieved). I understand that no further written response to NRC will be required, unless specifically requested.

Title	Printed Name	Signature	Date
LICENSEE'S REPRESENTATIVE			
NRC INSPECTOR	Geoffrey M. Warren		8/27/09

NRC FORM 591M PART 1 (10-2003)

187

NRC FORM 591M PART 3
(10-2003) 10 CFR 2.201

Docket File Information

U.S. NUCLEAR REGULATORY COMMISSION

SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION

1. LICENSEE	2. NRC/REGIONAL OFFICE
Scott Memorial Hospital REPORT NUMBER(S) 2009-001	**NRC Region III** **2443 Warrenville Road, Suite 210** **Lisle, Illinois 60532-4351**

3. DOCKET NUMBER(S)	4. LICENSE NUMBER(S)	5. DATE(S) OF INSPECTION
030-33192	13-26500-01	August 27, 2009

6. INSPECTION PROCEDURES USED	7. INSPECTION FOCUS AREAS
87131	03.01 – 03.08

SUPPLEMENTAL INSPECTION INFORMATION

1. PROGRAM CODE(S)	2. PRIORITY	3. LICENSEE CONTACT	4. TELEPHONE NUMBER
02120	3	Bart Rydzewski, M.D., RSO	812-752-3456

[X] Main Office Inspection — Next Inspection Date: Aug. 2012

[ ] Field Office

[ ] Temporary Job Site Inspection

PROGRAM SCOPE

The licensee was a 100-bed hospital located in Scottsburg, Indiana, with authorization to use byproduct materials in Sections 35.100 and 35.200, and iodine-131 for diagnostic procedures under 35.300. However, the licensee had not performed any procedures using iodine-131 since the previous inspection. Licensed activities were conducted only at the location indicated on the license. The nuclear medicine department was staffed with one full-time nuclear medicine technologist. The licensee's nuclear medicine staff typically administered 160 diagnostic doses monthly. The licensee performed cardiac, hepatobiliary, bone, and other studies using unit doses received from a licensed nuclear pharmacy. The doses were primarily technetium-99m, with occasional gallium-67 and iodine-123 doses, and thallium-201 doses were used when necessary. All waste was either held for decay-in-storage (DIS) or returned to the nuclear pharmacy.

Performance Observations

The inspector was unable to observe any diagnostic administrations of licensed material because no patients were scheduled at the time of the inspection. The inspector observed a package receipt survey and wipes, and the technologist demonstrated dose calibrator constancy checks, wipe counter and survey meter QC, dose preparation, administration, and disposal, and daily and weekly contamination surveys, and the inspector noted no concerns with these activities. Interviews with licensee personnel indicated adequate knowledge of radiation safety concepts and procedures. The inspector performed independent and confirmatory radiation measurements which indicated results consistent with licensee survey records and postings.