

*MC*



# THE QUEEN'S MEDICAL CENTER

1301 Punchbowl Street • Honolulu, Hawaii 96813 • Phone (808) 538-9011 • FAX: (808) 547-4646 • www.queens.org

January 3, 2011

Nuclear Materials Licensing Branch  
U.S. NRC Region IV  
612 E. Lamar Blvd., Suite 400  
Arlington, TX 76011-4125

RECEIVED  
JAN 15 2011  
NRC REGION IV

**Docket: 030-14522**  
**License: 53-16533-02**

RE: Amendment to add Jessica Fagerstrom as Authorized Medical Physicist (AMP)

Greetings:

Please amend our license to add Jessica Fagerstrom as an Authorized Medical Physicist for Iridium-192 in a High Dose Rate remote afterloader unit for calibration, spot-checks, and training. The completed Form 313A is enclosed for Jessica Fagerstrom's documented training and experience and the preceptor's attestation.

For any additional information, please contact me at (808)547-4884 or email to boyado@queens.org. Thank you very much.

Sincerely,

Brian Oyadomari  
Radiation Safety Officer

**AUTHORIZED MEDICAL PHYSICIST TRAINING AND EXPERIENCE  
AND PRECEPTOR ATTESTATION  
[10 CFR 35.51]**

APPROVED BY OMB: NO. 3150-0120  
EXPIRES: 3/31/2012

Name of Proposed Authorized Medical Physicist

Jessica Fagerstrom

- Requested Authorization(s) (check all that apply)**
- 35.400 Ophthalmic use of strontium-90
  - 35.600 Teletherapy unit(s)
  - 35.600 Remote afterloader unit(s)
  - 35.600 Gamma stereotactic radiosurgery unit(s)

**PART I -- TRAINING AND EXPERIENCE**  
*(Select one of the three methods below)*

\*Training and Experience, including Board Certification, must have been obtained within the 7 years preceding the date of application or the individual must have obtained related continuing education and experience since the required training and experience was completed. Provide dates, duration, and description of continuing education and experience related to the uses checked above.

- 1. Board Certification**
  - a. Provide a copy of the board certification.
  - b. Go to the table in 3.c. and describe training provider and dates of training for each type of use for which authorization is sought.
  - c. Skip to and complete Part II Preceptor Attestation.
- 2. Current Authorized Medical Physicist Seeking Additional Authorization for use(s) checked above**
  - a. Go to the table in section 3.c. to document training for new device.
  - b. Skip to and complete Part II Preceptor Attestation
- 3. Education, Training, and Experience for Proposed Authorized Medical Physicist**
  - a. Education: Document master's or doctor's degree in physics, medical physics, other physical science, engineering, or applied mathematics from an accredited college or university.

Degree	Major Field
M.S. Medical Physics	Medical Physics
College or University	
University of Wisconsin, Madison	

b. Supervised Full-Time Medical Physics Training and Work Experience in clinical radiation facilities that provide high-energy external beam therapy (photons and electrons with energies greater than or equal to 1 million electron volts) and brachytherapy services.

Yes. Completed 1 year of full-time training in medical physics (for areas identified below) under the supervision of Emily Robinson, M.S. who meets the requirements for an Authorized Medical Physicist.

**AND**

Yes. Completed 1 year of full-time work experience in medical physics (for areas identified below) under the supervision of Emily Robinson, M.S. who meets the requirements for

**AUTHORIZED MEDICAL PHYSICIST TRAINING AND EXPERIENCE AND PRECEPTOR ATTESTATION (continued)**

**3. Education, Training, and Experience for Proposed Authorized Medical Physicist (continued)**

**b. Supervised Full-Time Medical Physics Training and Work Experience (continued)**

*If more than one supervising individual is necessary to document supervised training, provide multiple copies of this page.*

Description of Training/ Experience	Location of Training/License or Permit Number of Training Facility/Medical Devices Used+	Dates of Training*	Dates of Work Experience*
Medical Physics	Queen's Medical Center/License # 53-16533-02/Varian 21EX linacs, TomoTherapy, Varian GammaMed HDR, Integra XKnife, Varian VariSeed PSI, Philips Pinnacle planning system	Sept 2008 - Sept 2009	Oct 2009 - Oct 2010
Performing sealed source leak tests and inventories	Queen's Medical Center/License # 53-16533-02/Varian GammaMed HDR	Sept 2008 - Sept 2009	Oct 2009 - Oct 2010
Performing decay corrections	Queen's Medical Center/License # 53-16533-02/Varian VariSeed prostate seed implant dosimetry system and Eclipse Brachytherapy planning system	Sept 2008 - Sept 2009	Oct 2009 - Oct 2010
Performing full calibration and periodic spot checks of external beam treatment unit(s)	Queen's Medical Center/License # 53-16533-02/Varian 21EX linacs equipped with PortalVision and TomoTherapy	Sept 2008 - Sept 2009	Oct 2009 - Oct 2010
Performing full calibration and periodic spot checks of stereotactic radiosurgery unit(s)	Queen's Medical Center/License # 53-16533-02/Integra XKnife System	Sept 2008 - Sept 2009	Oct 2009 - Oct 2010
Performing full calibration and periodic spot checks of remote afterloading unit(s)	Queen's Medical Center/License # 53-16533-02/Varian GammaMed HDR brachytherapy remote afterloading system	Sept 2008 - Sept 2010	Oct 2009 - Oct 2010
Conducting radiation surveys around external beam treatment unit(s), stereotactic radiosurgery unit(s), remote after loading unit(s)	Queen's Medical Center/License # 53-16533-02/survey meters such as Victoreen 450P ion chambers	Sept 2008 - Sept 2009	Oct 2009 - Oct 2010

Supervising Individual\*\*

Emily Robinson

License/Permit Number listing supervising individual as an authorized Medical Physicist

License # 53-16533-02

for the following types of use:

- Remote afterloader unit(s)       Teletherapy unit(s)       Gamma stereotactic radiosurgery unit(s)

+ Training and work experience must be conducted in clinical radiation facilities that provide high-energy external beam therapy (photons and electrons with energies greater than or equal to 1 million electron volts) and brachytherapy services.

\* 1 year of Full-time medical physics training and 1 year of full time work experience cannot be concurrent.

\*\* If the supervising medical physicist is not an authorized medical physicist, the licensee must submit evidence that the supervising medical

**AUTHORIZED MEDICAL PHYSICIST TRAINING AND EXPERIENCE AND PRECEPTOR ATTESTATION (continued)**

**3. Education, Training, and Experience for Proposed Authorized Medical Physicist (continued)**

c. Describe training provider and dates of training for each type of use for which authorization is sought.

Description of Training	Training Provider and Dates		
	Remote Afterloader	Teletherapy	Gamma Stereotactic Radiosurgery
Hands-on device operation	Sept 2008 - Sept 2009. Trainer: Emily Robinson for Varian GammaMed HDR brachytherapy		N/A
Safety procedures for the device use	Sept 2008 - Sept 2009. Trainer: Emily Robinson, with regular continuing updates		N/A
Clinical use of the device	Sept 2008 - Sept 2009. Trainer: Emily Robinson		N/A
Treatment planning system operation	Sept 2008 - Sept 2009. Trainer: Emily Robinson for Eclipse Brachytherapy planning		N/A

Supervising Individual  
*If training is provided by Supervising Medical Physicist, (if more than one supervising individual is necessary to document supervised training, provide multiple copies of this page.)*

Emily Robinson License/Permit Number listing supervising individual as an authorized Medical Physicist  
License # 53-16533-02

for the following types of use:

- Remote afterloader unit(s)       Teletherapy unit(s)       Gamma stereotactic radiosurgery unit(s)

If Applicable:

Authorization Sought	Device	Training Provided By	Dates of Training
35.400 Ophthalmic Use of strontium-90			

**AUTHORIZED MEDICAL PHYSICIST TRAINING AND EXPERIENCE AND PRECEPTOR ATTESTATION (continued)**

**PART II – PRECEPTOR ATTESTATION**

Note: This part must be completed by the individual's preceptor. The preceptor does not have to be the supervising individual as long as the preceptor provides, directs, or verifies training and experience required. If more than one preceptor is necessary to document experience, obtain a separate preceptor statement from each.

**First Section**

Check one of the following:

**1. Board Certification**

I attest that \_\_\_\_\_ has satisfactorily completed the requirements in  
Name of Proposed Authorized Medical Physicist  
10 CFR 35.51(a)(1) and (a)(2).

**OR**

**2. Education, Training, and Experience**

I attest that Jessica Fagerstrom has satisfactorily completed the 1-year of full-time  
Name of Proposed Authorized Medical Physicist  
training in medical physics and an additional year of full-time work experience as required by 10 CFR 35.51(b)(1).

**AND**

**Second Section**

Complete the following:

I attest that Jessica Fagerstrom has training for the types of use for which authorization  
Name of Proposed Authorized Medical Physicist  
is sought that include hands-on device operation, safety procedures, clinical use, and the operation of a treatment planning system.

**AND**

**Third Section**

Complete the following:

I attest that Jessica Fagerstrom has achieved a level of competency sufficient to  
Name of Proposed Authorized Medical Physicist  
function independently as an Authorized Medical Physicist for the following:

- 35.400 Ophthalmic use of strontium-90     35.600 Teletherapy unit(s)  
 35.600 Remote afterloader unit(s)     35.600 Gamma stereotactic radiosurgery unit(s)

**AND**

**Fourth Section**

Complete the following for preceptor attestation and signature:

- I meet the requirements in 10 CFR 35.51, or equivalent Agreement State requirements for Authorized Medical Physicist for the following:  
 35.400 Ophthalmic use of strontium-90     35.600 Teletherapy unit(s)  
 35.600 Remote afterloader unit(s)     35.600 Gamma stereotactic radiosurgery unit(s)

Name of Preceptor	Signature	Telephone Number	Date
Emily Robinson		(808) 537-7346	11/9/10

ORIGIN ID: HIKA (808) 547-4348  
SHIPPING  
QUEENS MEDICAL CENTER  
1301 PUNCHBOWL ST

HONOLULU, HI 96813  
UNITED STATES US

SHIP DATE: 09JAN11  
ACTWGT: 0.4 LB  
CAD: 0751243/CAFE2471

BILL THIRD PARTY

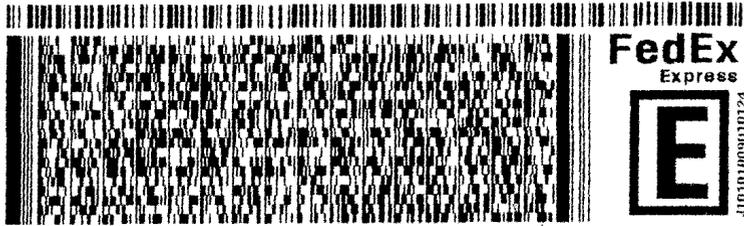
TO

**U.S. NUCLEAR REGULATORY COMMISSION  
612 E. LAMAR BOULEVARD SUITE 400**

**ARLINGTON TX 760114125**

REF: CC:2418

DEPT: RADIATION THERAPY

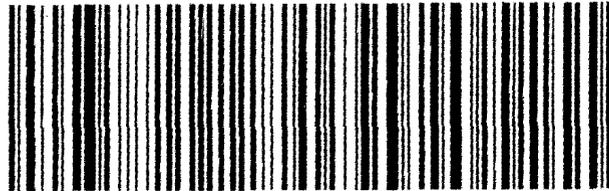


**WED - 05 JAN A1  
\*\* 2DAY \*\***

TRK# 4636 4597 2262  
0201

**SR FWHA**

**76011  
TX - US  
DFW**



505C1/DE77/DA47

1-24-2011

DATE

This is to acknowledge the receipt of your letter/application dated 1-03-2011, 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 other 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** 574251.  
When calling to inquire about this action, please refer to this mail control number.  
You may call me at 817-860-8103.

Sincerely,

*Colleen Murnahan*  
Licensing Assistant

BETWEEN:

Accounts Receivable/Payable  
and  
Regional Licensing Branches

[ FOR ARPB USE ]  
INFORMATION FROM LTS ...

Program Code: 02230  
Status Code: Pending Amendment  
Fee Category: 3E 7C  
Exp. Date:  
Fee Comments:  
Decom Fin Assur Req: N

### License Fee Worksheet - License Fee Transmittal

#### A. REGION

##### 1. APPLICATION ATTACHED

Applicant/Licensee: QUEEN'S MEDICAL CENTER, THE  
Received Date: 01/05/2011  
Docket Number: 3014522  
Mail Control Number: 574251  
License Number: 53-16533-02  
Action Type: Amendment

##### 2. FEE ATTACHED

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

##### 3. COMMENTS

Signed: Colleen Murnahan  
Date: 1-14-2011

#### 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: \_\_\_\_\_