



CONVERSATION RECORD

NAME OF PERSON(S)/TITLE CONTACTED OR IN CONTACT WITH YOU		DATE OF CONTACT	TYPE OF CONVERSATION	
Ann H. Maitz, M.S.		12/18/2018	<input type="checkbox"/> E-MAIL	<input type="checkbox"/> INCOMING <input checked="" type="checkbox"/> OUTGOING
E-MAIL ADDRESS	TELEPHONE NUMBER		<input checked="" type="checkbox"/> TELEPHONE	
Ann.Maitz@beaumont.org		248-551-1194		
ORGANIZATION		DOCKET NUMBER(S)		
Beaumont Health System		030-37359		
LICENSE NAME AND NUMBER(S)		MAIL CONTROL NUMBER(S)		
Beaumont Health System, 21-01333-02		610456		
SUBJECT Additional information required regarding the requested use of Icon				
SUMMARY AND ACTION REQUIRED (IF ANY)				
<p>1. Please, confirm the new maximum possession limit only for Icon. If you request an activity slightly less than 10,000 Ci we will be able to take off the financial assurance condition of your license in the future.</p> <p>2. Please submit the training documentation for the AUs, AMPs and RSO from the vendor as we discussed in accordance with the guidance, "Leksell Gamma Knife Perfexion and Leksell Gamma Knife Icon", Revision 0.</p> <p>3. Please resubmit commitments from the referenced guidance, Rev. O (pages 11, 12, 13, 14)</p> <p>4. Please resubmit the table with the treatment room and the adjacent areas indicating whether a room is restricted or unrestricted.</p> <p>5. Please resubmit the diagram of the treatment room providing the dimensions of the room and the distances from the Icon unit to the adjacent barriers/walls and ceiling.</p>				
NAME OF PERSON DOCUMENTING CONVERSATION				
MAGDALENA GYLLER				
SIGNATURE			DATE OF SIGNATURE	
Magdalena Gyller			12/18/18	