

V A MEDICAL AND PO CENTER
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APR 29 1982

455/115

Region III Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
101 Marietta St. N.W., Suite 3100
Atlanta, Georgia 30303

30-3514

RE: NRC License No. 52-04359-01

Gentlemen:

Pursuant to the requirements of 10 CFR 35.43, we submit a report of misadministrations for the first calendar quarter of 1982.

A total of three misadministrations occurred during this period, each one a diagnostic dose differing from the prescribed dose by more than 50 percent. All three occurred on the same day. The principal contributing factor was a technologist's error in interpreting the prescribed dose.

Corrective action that is being implemented includes refresher training of nuclear medicine technologists in the procedures for determining and documenting administered doses.

Sincerely yours,

JAMES G. MARTIN
Center Director

cc: Isotope & Radiation Safety Committee (115)