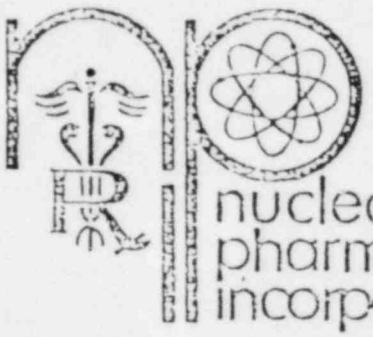
Regulatory Affairs
N.R.C.
TELEPHONE (414) 476-1152



933 MAYFAIR ROAD, SUITE 307
WAUWATOSA, WISCONSIN 53226

May 8, 1981

A.B. Davis
Branch Chief
Fuel Facility and Materials
Safety Branch
U.S. Nuclear Regulatory Commission
Region III
799 Rosevelt Road
Glen Ellyn, IL. 60137

Re: 48-17466-01MD

Dear Mr. Davis:

On May 7, 1981, two doses of approximately 20.0 mCi of Tc99m M.A.A. were dispensed instead of the ordered Tc99m M.D.P. These doses were delivered to St. Mary Medical Center in Racine, Wisconsin where they were administered to patients by hospital personnel.

Nuclear Pharmcy Incorporated, (N.P.I.), has investigated the cause of the event and has determined that it was a professional error by the pharmacist who failed to assure that the dose dispensed was exactly as ordered. N.P.I. will redouble our efforts in the future to prevent this from reoccurring.

N.P.I. has notified this hospital of our intent to report this event to the N.R.C.

Should you have any questions regarding the above, please feel free to contact me.

Sincerely,
NUCLEAR PHARMACY INCORPORATED

Jon M. Reavis
Radiation Safety Officer