



Upper Michigan  
Cancer Center

**MARQUETTE GENERAL HOSPITAL**

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**Robert C. Neldberg**  
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*May 23, 1994*

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225-3500

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225-3322

Radiation Oncology  
225-3103

Research Department  
225-3464

Joint Registry  
225-3464

Beacon House  
228-5276

Cancer Related  
Support Groups  
225-3500

Oncology Social Worker  
225-3477

Enterostomal Therapy  
225-3411

*U.S. Nuclear Regulatory Commission  
Region III  
John D. Jones, Acting Chief  
Nuclear Materials Inspection  
Section 2  
801 Warrenville Road  
Lisle, Illinois 60532-4351*

*SUBJECT: Reply to Notice of Violation Dated May 16, 1994*

*Violation: 10CFR 35.33(a)(3) requires, in part, that the licensee shall notify the patient of a misadministration no later than 24 hours after its discovery.*

*10CFR 35.33(a)(4) requires, in part, that if the patient was notified, the licensee shall also furnish, within 15 days after discovery of the misadministration a written report to the patient by sending either:*

*(i) a copy of the report that was submitted to the NRC; or*

*(ii) a brief description of both the event and the consequences as they may affect the patient, provided a statement is included that the report submitted to the NRC can be obtained from the licensee.*

*1. Due to an misinterpretation of 10CFR 35.33(a)(3)-(4) the patient involved in a misadministration was not furnished written notification within 15 days after discovery of the misadministration.*

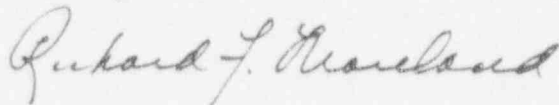
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U.S. Nuclear Regulatory Commission  
John D. Jones, Acting Chief  
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2. *During subsequent phone conversations and letters (March 30, 1994 thru April 26, 1994) with your office this misinterpretation was clarified and a letter, dated April 26, 1994 was sent to the patient. This contained a brief description of the event and possible consequences. It also informed the patient that a copy of the technical report submitted to the NRC could be obtained from the hospital.*
3. *The results of this Notice of Violation and the correct interpretation of 10CFR 35.33(a)(3)-(4) has been discussed with pertinent hospital and medical staff and the proper course of action in future occurrences was mapped out.*
4. *The above review of regulations and the Notice of Violation took place on April 26, 1994. Future occurrences will be reviewed by the Radiation Safety Officer and the Radiation Safety Committee.*

*If there are any questions regarding this matter you may contact me at (906) 225-3102.*

*Sincerely,*



*Richard F. Moreland, Ph.D.  
Radiation Safety Officer*

*RFM/mmo*