FORM NRC-313M
(8-78)
10 CFR 35

U.S. NUCLEAR REGULATORY COMMISSION

APPLICATION FOR MATERIALS LICENSE – MEDICAL

Approved:
GAO R0557

INSTRUCTIONS – *Complete Items 1 through 26 if this is an initial application or an application for renewal of a license. Use supplemental sheets where necessary. Item 26 must be completed on all applications and signed. Retain one copy. Submit original and one copy of entire application to : Director, Office of Nuclear Materials Safety and Safeguards, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555. Upon approval of this application, the applicant will receive a Materials License. An NRC Materials License is issued in accordance with the general requirements contained in Title 10, Code of Federal Regulations, Part 30, and the Licensee is subject to Title 10, Code of Federal Regulations, Parts 19, 20 and 35 and the license fee provision of Title 10, Code of Federal Regulations, Part 170. The license fee category should be stated in Item 26 and the appropriate fee enclosed.*

1.a. NAME AND MAILING ADDRESS OF APPLICANT *(institution, firm, clinic, physician, etc.)* INCLUDE ZIP CODE

Nuclear & Radiologic Imaging Physicians, P.C.
2151 Livernois Suite 201
Troy, Michigan 48083

TELEPHONE NO.: AREA CODE (313) 362 1360

1.b. STREET ADDRESS(ES) AT WHICH RADIOACTIVE MATERIAL WILL BE USED *(If different from 1.a.)* INCLUDE ZIP CODE

See attached NRC-313M

Item 1.b.

2. PERSON TO CONTACT REGARDING THIS APPLICATION

Thomas M. Kumpuris, M.S.

TELEPHONE NO.: AREA CODE (313) 494 8417

3. THIS IS AN APPLICATION FOR: *(Check appropriate item)*

a. [X] NEW LICENSE
b. [ ] AMENDMENT TO LICENSE NO. ______
c. [ ] RENEWAL OF LICENSE NO. ______

4. INDIVIDUAL USERS *(Name individuals who will use or directly supervise use of radioactive material. Complete Supplements A and B for each individual.)*

Subhash C. Khullar, M.D.
Frederick C. Stebner, M.D.

5. RADIATION SAFETY OFFICER (RSO) *(Name of person designated as radiation safety officer. If other than individual user, complete resume of training and experience as in Supplement A.)*

Subhash C. Khullar, M.D.

6.a. RADIOACTIVE MATERIAL FOR MEDICAL USE

RADIOACTIVE MATERIAL LISTED IN:	ITEMS DESIRED "X"	MAXIMUM POSSESSION LIMITS (In millicuries)
10 CFR 31.11 FOR IN VITRO STUDIES		
10 CFR 35.100, SCHEDULE A, GROUP I	X	AS NEEDED
10 CFR 35.100, SCHEDULE A, GROUP II	X	AS NEEDED
10 CFR 35.100, SCHEDULE A, GROUP III		
10 CFR 35.100, SCHEDULE A, GROUP IV		AS NEEDED
10 CFR 35.100, SCHEDULE A, GROUP V		AS NEEDED
10 CFR 35.100, SCHEDULE A, GROUP VI		

ADDITIONAL ITEMS:	MARK ITEMS DESIRED "X"	MAXIMUM POSSESSION LIMITS (In millicuries)
IODINE-131 AS IODIDE FOR TREATMENT OF HYPERTHYROIDISM		
PHOSPHORUS-32 AS SOLUBLE PHOSPHATE FOR TREATMENT OF POLYCYTHEMIA VERA, LEUKEMIA AND BONE METASTASES		
PHOSPHORUS-32 AS COLLOIDAL CHROMIC PHOSPHATE FOR INTRACAVITARY TREATMENT OF MALIGNANT EFFUSIONS.		
GOLD-198 AS COLLOID FOR INTRACAVITARY TREATMENT OF MALIGNANT EFFUSIONS.		
IODINE-131 AS IODIDE FOR TREATMENT OF THYROID CARCINOMA		
XENON-133 AS GAS OR GAS IN SALINE FOR BLOOD FLOW STUDIES AND PULMONARY FUNCTION STUDIES.		

6.b. RADIOACTIVE MATERIAL FOR USES NOT LISTED IN ITEM 6.a. *(Sealed sources up to 3 mCi used for calibration and reference standards are authorized under Section 35.14(d), 10 CFR Part 35, and NEED NOT BE LISTED.)*

ELEMENT AND MASS NUMBER	CHEMICAL AND/OR PHYSICAL FORM	MAXIMUM NUMBER OF MILLICURIES OF EACH FORM	DESCRIBE PURPOSE OF USE
NOT APPLICABLE			

Applicant Subhash C. Khullar, MD
Check No. 1341
Amount/Fee Category 580-7C
Type of Fee application
Date Check Recd. 3/27/85
Recd By Jackson

8505030482 850417
REG3 LIC30
21-24472-01 PDR

CONTROL NO. 78520

INFORMATION REQUIRED FOR ITEMS 7 THROUGH 23

For Items 7 through 23, check the appropriate box(es) and submit a detailed description of all the requested information. Begin each item on a separate sheet. Identify the item number and the date of the application in the lower right corner of each page. If you indicate that an appendix to the medical licensing guide will be followed, do not submit the pages, but specify the revision number and date of the referenced guide: Regulatory Guide 10.8 , Rev. ______________ Date: __________________

7. MEDICAL ISOTOPES COMMITTEE	
NA	Names and Specialties Attached; and
	Duties as in Appendix B; or *(Check One)*
	Equivalent Duties Attached
8. TRAINING AND EXPERIENCE	
X	Supplements A & B Attached for Each Individual User; and
X	Supplement A Attached for RSO.
9. INSTRUMENTATION *(Check One)*	
X	Appendix C Form Attached; or
	List by Name and Model Number
10. CALIBRATION OF INSTRUMENTS	
X	Appendix D Procedures Followed for Survey Instruments; or *(Check One)*
	Equivalent Procedures Attached; and
X	Appendix D Procedures Followed for Dose Calibrator; or *(Check One)*
	Equivalent Procedures Attached
11. FACILITIES AND EQUIPMENT	
X	Description and Diagram Attached
12. PERSONNEL TRAINING PROGRAM	
X	Description of Training Attached
13. PROCEDURES FOR ORDERING AND RECEIVING RADIOACTIVE MATERIAL	
X	Detailed Information Attached
14. PROCEDURES FOR SAFELY OPENING PACKAGES CONTAINING RADIOACTIVE MATERIALS *(Check One)*	
X	Appendix F Procedures Followed; or
	Equivalent Procedures Attached

15. GENERAL RULES FOR THE SAFE USE OF RADIOACTIVE MATERIAL *(Check One)*	
X	Appendix G Rules Followed; or
	Equivalent Rules Attached
16. EMERGENCY PROCEDURES *(Check One)*	
X	Appendix H Procedures Followed; or
	Equivalent Procedures Attached
17. AREA SURVEY PROCEDURES *(Check One)*	
X	Appendix I Procedures Followed; or
X	Equivalent Procedures Attached
18. WASTE DISPOSAL *(Check One)*	
X	Appendix J Form Attached; or
	Equivalent Information Attached
19. THERAPEUTIC USE OF RADIOPHARMACEUTICALS *(Check One)*	
NA	Appendix K Procedures Followed; or
	Equivalent Procedures Attached
20. THERAPEUTIC USE OF SEALED SOURCES	
NA	Detailed Information Attached; and
	Appendix L Procedures Followed; or *(Check One)*
	Equivalent Procedures Attached
21. PROCEDURES AND PRECAUTIONS FOR USE OF RADIOACTIVE GASES (e.g., Xenon – 133)	
NA	Detailed Information Attached
22. PROCEDURES AND PRECAUTIONS FOR USE OF RADIOACTIVE MATERIAL IN ANIMALS	
NA	Detailed Information Attached
23. PROCEDURES AND PRECAUTIONS FOR USE OF RADIOACTIVE MATERIAL SPECIFIED IN ITEM 6.b	
NA	Detailed Information Attached

24. PERSONNEL MONITORING DEV

TYPE (Check appropriate box)			SUPPLIER	EXCHANGE FREQUENCY
a. WHOLE BODY		FILM	R. S. Landauer	Monthly
		TLD		
		OTHER (Specify)		
b. FINGER		FILM		
		TLD	R. S. Landauer	Monthly
		OTHER (Specify)		
c. WRIST		FILM		
		TLD		
		OTHER (Specify)		

d. OTHER *(Specify)*

25. FOR PRIVATE PRACTICE APPLICANTS ONLY

a. HOSPITAL AGREEING TO ACCEPT PATIENTS CONTAINING RADIOACTIVE MATERIAL

NAME OF HOSPITAL

MAILING ADDRESS

CITY | STATE | ZIP CODE

b. ATTACH A COPY OF THE AGREEMENT LETTER SIGNED BY THE HOSPITAL ADMINISTRATOR.

c. WHEN REQUESTING THERAPY PROCEDURES, ATTACH A COPY OF RADIATION SAFETY PRECAUTIONS TO BE TAKEN AND LIST AVAILABLE RADIATION DETECTION INSTRUMENTS.

26. CERTIFICATE
(This item must be completed by applicant)

The applicant and any official executing this certificate on behalf of the applicant named in Item 1a certify that this application is prepared in conformity with Title 10, Code of Federal Regulations, Parts 30 and 35, and that all information contained herein, including any supplements attached hereto, is true and correct to the best of our knowledge and belief.

a. LICENSE FEE REQUIRED
(See Section 170.31, 10 CFR 170)

(1) LICENSE FEE CATEGORY: 7C

(2) LICENSE FEE ENCLOSED: $ 580.00

b. APPLICANT OR CERTIFYING OFFICIAL *(Signature)* Subhash C Khullar

(1) NAME *(Type of Print)* Subhash C. Khullar, M.D.

(2) TITLE President

c. DATE March 1st, 1985

RECEIVED
MAR 15 1985
REGION III

FORM NRC-313M (8-78)

CONTROL NO. 78520

PRIVACY ACT STATEMENT

Pursuant to 5 U.S.C. 552a(e)(3), enacted into law by section 3 of the Privacy Act of 1974 (Public Law 93-579), the following statement is furnished to individuals who supply information to the Nuclear Regulatory Commission on Form NRC-313M. This information is maintained in a system of records designated as NRC-3 and described at 40 Federal Register 45334 (October 1, 1975).

1. **AUTHORITY** Sections 81 and 161(b) of the Atomic Energy Act of 1954, as amended (42 U.S.C. 2111 and 2201(b)).

2. **PRINCIPAL PURPOSE(S)** The information is evaluated by the NRC staff pursuant to the criteria set forth in 10 CFR Parts 30-36 to determine whether the application meets the requirements of the Atomic Energy Act of 1954, as amended, and the Commission's regulations, for the issuance of a radioactive material license or amendment thereof.

3. **ROUTINE USES** The information may be used: (a) to provide records to State health departments for their information and use; and (b) to provide information to Federal, State, and local health officials and other persons in the event of incident or exposure, for their information, investigation, and protection of the public health and safety. The information may also be disclosed to appropriate Federal, State, and local agencies in the event that the information indicates a violation or potential violation of law and in the course of an administrative or judicial proceeding. In addition, this information may be transferred to an appropriate Federal, State, or local agency to the extent relevant and necessary for a NRC decision or to an appropriate Federal agency to the extent relevant and necessary for that agency's decision about you. A copy of the license issued will routinely be placed in the NRC's Public Document Room, 1717 H Street, N.W., Washington, D.C.

4. **WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION** Disclosure of the requested information is voluntary. If the requested information is not furnished, however, the application for radioactive material license, or amendment thereof, will not be processed.

5. **SYSTEM MANAGER(S) AND ADDRESS** Director, Division of Fuel Cycle and Material Safety, Office of Nuclear Material Safety and Safeguards, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555.

Nuclear and Radiologic Imaging Physicians, P.C.

NRC-313M

Item 1.b.

Nuclear & Radiologic Imaging Physicians, P.C.
2151 Livernois   Suite 201
Troy, Michigan   48083

Nuclear & Radiologic Imaging Physicians, P.C.
31500 Schoolcraft
Livonia, Michigan   48150

Nuclear & Radiologic Imaging Physicians, P.C.
Fisher Building   Suite 1073
Detroit, Michigan   48202

NRC FORM 313M SUPPLEMENT A
(9-81)

U.S. NUCLEAR REGULATORY COMMISSION

TRAINING AND EXPERIENCE
AUTHORIZED USER OR RADIATION SAFETY OFFICER

1. NAME OF AUTHORIZED USER OR RADIATION SAFETY OFFICER	2. STATE OR TERRITORY IN WHICH LICENSED TO PRACTICE MEDICINE
Subhash C. Khullar, M.D.	Michigan

3. CERTIFICATION

SPECIALTY BOARD A	CATEGORY B	MONTH AND YEAR CERTIFIED C
American Board of Nuclear Medicine	Nuclear Medicine	1975

4. TRAINING RECEIVED IN BASIC RADIOISOTOPE HANDLING TECHNIQUES

FIELD OF TRAINING A	LOCATION AND DATE(S) OF TRAINING B	TYPE AND LENGTH OF TRAINING: LECTURE/LABORATORY COURSES (Hours) C	TYPE AND LENGTH OF TRAINING: SUPERVISED LABORATORY EXPERIENCE (Hours) D
a. RADIATION PHYSICS AND INSTRUMENTATION			
b. RADIATION PROTECTION			
c. MATHEMATICS PERTAINING TO THE USE AND MEASUREMENT OF RADIOACTIVITY			
d. RADIATION BIOLOGY			
e. RADIOPHARMACEUTICAL CHEMISTRY			

5. EXPERIENCE WITH RADIATION. *(Actual use of Radioisotopes or Equivalent Experience)*

ISOTOPE	MAXIMUM AMOUNT	WHERE EXPERIENCE WAS GAINED	DURATION OF EXPERIENCE	TYPE OF USE

NRC FORM 313M SUPPLEMENT A
(9-81)

U.S. NUCLEAR REGULATORY COMMISSION

TRAINING AND EXPERIENCE
AUTHORIZED USER OR RADIATION SAFETY OFFICER

1. NAME OF AUTHORIZED USER OR RADIATION SAFETY OFFICER	2. STATE OR TERRITORY IN WHICH LICENSED TO PRACTICE MEDICINE
Frederick C. Stebner, M.D.	Michigan

3. CERTIFICATION

SPECIALTY BOARD A	CATEGORY B	MONTH AND YEAR CERTIFIED C
American Board of Nuclear Medicine	Nuclear Medicine	March, 1972

4. TRAINING RECEIVED IN BASIC RADIOISOTOPE HANDLING TECHNIQUES

FIELD OF TRAINING A	LOCATION AND DATE(S) OF TRAINING B	TYPE AND LENGTH OF TRAINING	
		LECTURE/ LABORATORY COURSES *(Hours)* C	SUPERVISED LABORATORY EXPERIENCE *(Hours)* D
a. RADIATION PHYSICS AND INSTRUMENTATION			
b. RADIATION PROTECTION			
c. MATHEMATICS PERTAINING TO THE USE AND MEASUREMENT OF RADIOACTIVITY			
d. RADIATION BIOLOGY			
e. RADIOPHARMACEUTICAL CHEMISTRY			

5. EXPERIENCE WITH RADIATION. *(Actual use of Radioisotopes or Equivalent Experience)*

ISOTOPE	MAXIMUM AMOUNT	WHERE EXPERIENCE WAS GAINED	DURATION OF EXPERIENCE	TYPE OF USE

APPENDIX C

INSTRUMENTATION

1. Survey meters

   a. Manufacturer's name: BICRON Electronic Products Group

      Manufacturer's model number: Surveyor 2000

      Number of instruments available: Two (2)

      Minimum range: 0.0 mR/hr to 0.2 mR/hr

      Maximum range: 0.0 mR/hr to 2000 mR/hr

   b. Manufacturer's name: ______

      Manufacturer's model number: ______

      Number of instruments available: ______

      Minimum range: ______ mR/hr to ______ mR/hr

      Maximum range: ______ mR/hr to ______ mR/hr

2. Dose calibrator

   Manufacturer's name: Capintec

   Manufacturer's model number: CRC-7

   Number of instruments available: One (1)

3. Instruments used for diagnostic procedures

Type of Instrument	Manufacturer's Name	Model No.
Large Field Gamma Camera	Siemens	ZLC 370

4. Other (e.g., liquid scintillation counter, area monitor, velometer)

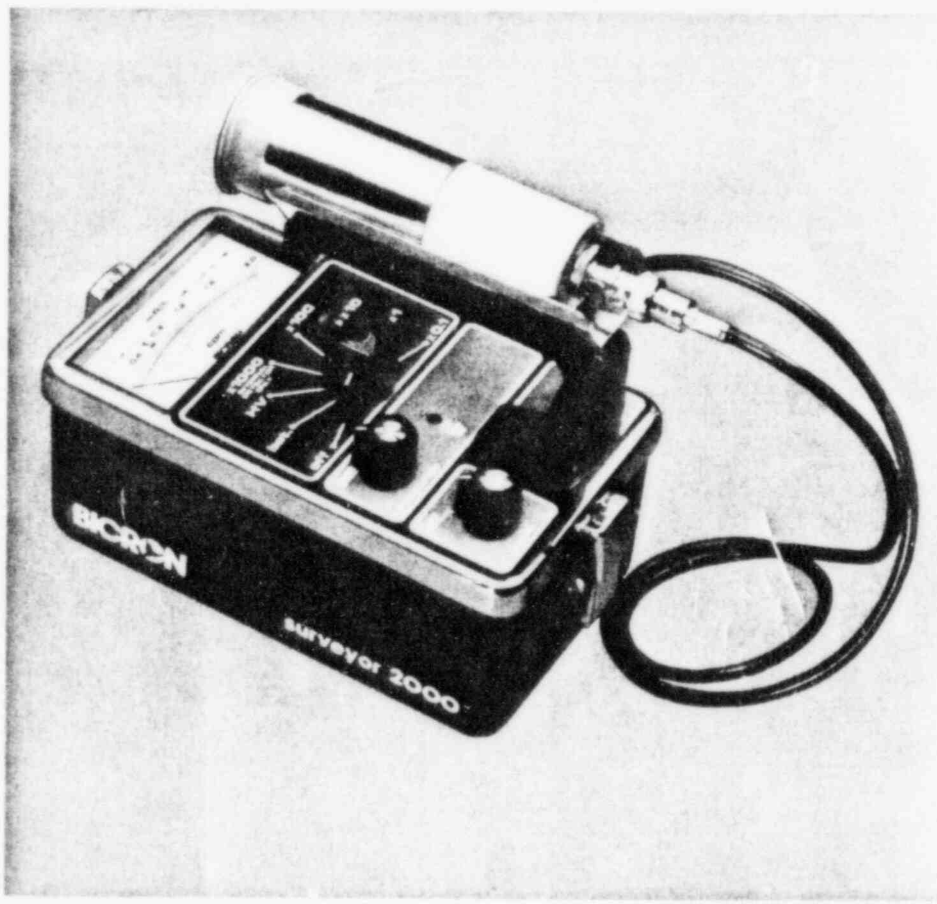
   Primalert-35 room monitor

CONTROL NO. 78520

surveyor 2000™

Features

- SINGLE 9-VOLT BATTERY
- EXCLUSIVE HV CHECK
- VARIABLE RESPONSE TIME
- WIDE-VIEW METER
- ANTI-SATURATION CIRCUIT
- DEAD TIME COMPENSATION
- UP TO 2000 mR/h



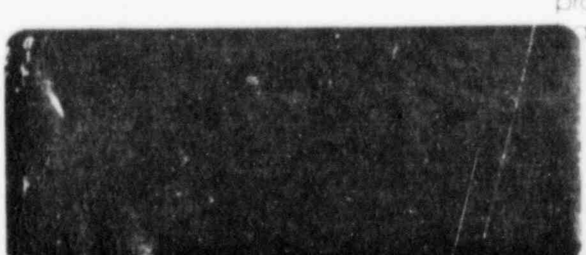
Shown with audio option

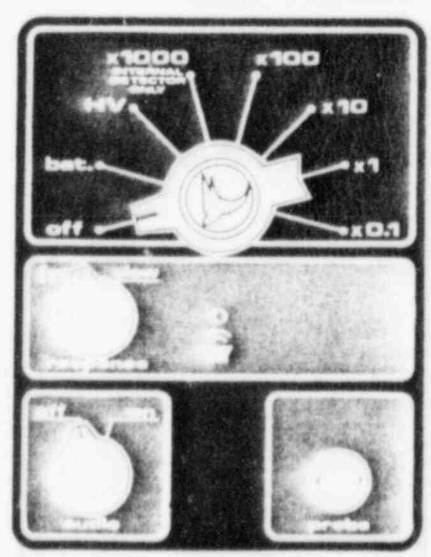
GENERAL: The surveyor 2000 is an ergonomically designed survey meter which embodies state-of the-art electronics and a unique concept in rugged construction.

All components are pretested to assure maximum reliability. The high-torque, rugged meter provides an easy-to-read display.

The utilization of an energy compensated internal GM tube for the high range (2000 mR/h), combined with the capability to accept all standard external GM probes makes this a very versatile survey meter.

The HV check is an exclusive safety test to verify operation of the detector power supply. Dead time compensation provides a truly linear response on all ranges and the anti-saturation circuit protects against over-range fold-back.





Shown with audio option

surveyor 2000™

Specifications

RADIATION DETECTED: Alpha, beta, gamma with external probe; gamma and x-ray with internal detector

DETECTOR: GM tube, internal; choice of GM probes external

RANGE: 0-2000 mR/h in 5 linear ranges; 0-240,000 cpm

HIGH VOLTAGE: Electronically stabilized; factory set at 900 V

CONNECTOR: MHV

ACCURACY: Within 15% of reading for ^{137}Cs between 20% and 100% of full scale (internal detector)

ENERGY RESPONSE: ±20% from 40keV to 1.2MeV (internal detector)

WARMUP TIME: None

SATURATION: >1000 R/h with exclusive anti saturation circuit

RESPONSE TIME: Switch selectable, optimized for each range, 0-90% of final reading as follows:

Range	Time: Fast	Slow
X0.1	6 sec	25 sec
X1	2 sec	6 sec
X10	1 sec	3 sec
X100	<1 sec	1 sec
X1000	<1 sec	1 sec

TEMPERATURE: Operational from −40° to +60°C

HUMIDITY: <5% change in reading from 10-95% RH

CONTROL: Eight-position rotary switch as indicated

BATTERY COMPLEMENT: Single 9-volt (MN1604 or equal). The additional battery holder may be used as storage of spare or parallel-wired.

BATTERY LIFE: >100 hours or >200 hours with parallel option

DISPLAY: Ruggedized, recessed, high-torque 1mA meter with 3.35 inch (8.51cm) scale marked 0-2 mR/h, 0-2400 cpm, "Bat. ok", "HV ok". Meter protected by impact-resistant Lexan® polycarbonate window.

GEOTROPISM: Within ±2% of full scale

SHOCK: 100g per lightweight machine of MIL-STD 202C, method 202B

HV TEST: Exclusive self test to verify detector HV power supply

VIBRATION: 5g in each of three mutually orthogonal axes at one or more frequencies from 10-33Hz

CONSTRUCTION: Splash-proof, shock proof, two-piece all-metal case. Scratch-resistant laminated control panel and Bicron Kleen-Krome™ trim on case top; durable black polyurethane painted handle and case bottom.

SIZE: 4.25 x 8 x 6.8" including handle and probe clip (10.8 x 20.3 x 17.3 cm)

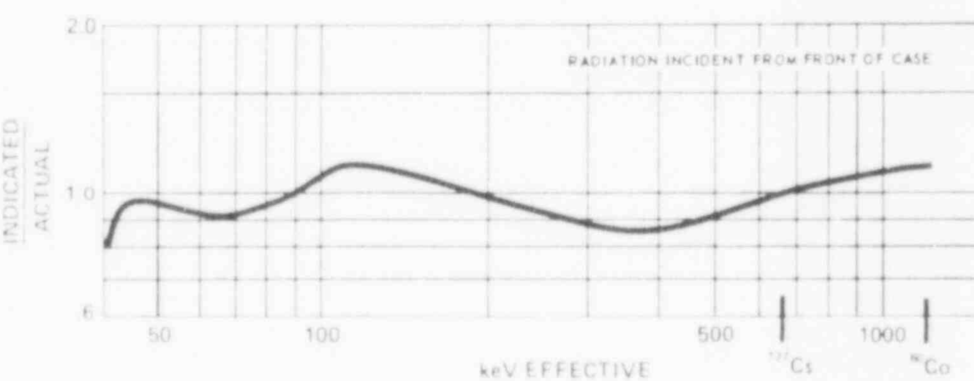
WEIGHT: 2.2 lbs (1 kg), excluding probe

Option

AUDIO OPTION: When specified, a built in speaker, with panel mounted on-off switch, provides audible "click" for each detector pulse. With the speaker off, an audible alarm sounds (if desired) when meter is >full scale on any range.

Typical Energy Response

INTERNAL DETECTOR ONLY



BICRON
Electronic Products

Bicron Corporation
Newbury, Ohio 44065
Telex 980474

Bicron Corporation
2410 AG Bodegraven, The Netherlands

Nuclear and Radiologic Imaging Physicians, P.C.

CALIBRATION OF SURVEY INSTRUMENTS

Check appropriate items.

__X__ 1. Survey instruments will be calibrated at least annually and following repair.

__X__ 2. Calibration will be performed at two points on each scale used for radiation protection purposes, i.e., at least up to 1 R/hr.

The two points will be approximately 1/3 and 2/3 of full scale. A survey instrument may be considered properly calibrated when the instrument readings are within $\pm$10 percent of the calculated or known values for each point checked. Readings within $\pm$20 percent are considered acceptable if a calibration chart, graph, or response factor is prepared, attached to the instrument, and used to interpret readings to within $\pm$10 percent. Also, when higher scales are not checked or calibrated, an appropriate precautionary note will be posted on the instrument.

3. Survey instruments will be calibrated

_____ a. By the manufacturer

_____ b. At the licensee's facility

(1) Calibration source

Manufacturer's name _____
Model no. _____
Activity in millicuries _____
or
Exposure rate at a specified distance _____
Accuracy _____
Traceability to primary standard _____

_____ (2) The calibration procedures in Section I of Appendix D will be used
or
_____ (3) The step-by-step procedures, including radiation safety procedures, are attached.

__X__ c. By a consultant or outside firm

(1) Name Medical Physics Consultants, Inc.

(2) Location Ann Arbor, MI 48103

(3) Procedures and sources

__X__ have been approved by NRC and are on file in License No. 21-20153-01

_____ have been approved by an Agreement State; a copy of the Agreement State license, the procedures, and a description of the sources are attached, and the consultant's report will contain the information on

_____ the attached "Certificate of Instrument Calibration."
_____ the consultant's reporting form as attached.

_____ are described in the attachment, and the consultant's report will contain the information on

_____ the attached "Certificate of Instrument Calibration."
_____ the consultant's reporting form as attached.

CONTROL NO. 78520

CERTIFICATE OF CALIBRATION - GAMMA SURVEY INSTRUMENTS

Calibration Date: ______________________

Facility: ____________________ City: ____________________ State: ____________________

Instrument Identification:

☐ G-M ☐ Ion Chamber ☐ ______________________

Manufacturer: __________________ Model No. __________________

Serial No. ____

Calibration Source
Radionuclide: ______________ Source Strength: ______________ mR/hr/mCi @ 1m

RANGE	OBSERVED mR/hr	ACTUAL mR/hr
X		
X		
X		
X		
X		

RANGE ANALYSIS

x ______	Within ± 10%	Correction Factor	______
		Correction Factor	______
x ______	Within ± 10%	Correction Factor	______
		Correction Factor	______
x ______	Within ± 10%	Correction Factor	______
		Correction Factor	______
x ______	Within ± 10%	Correction Factor	______
		Correction Factor	______
x ______	Within ± 10%	Correction Factor	______
		Correction Factor	______

Battery Change: YES ☐ NO ☐

Remarks: ____

____

NEXT CALIBRATION DATE: ______________________

CALIBRATED BY: ______________________

CALIBRATION OF DOSE CALIBRATOR

A. Sources Used for Linearity Test

(Check as appropriate)

__________ First elution from new Mo-99/Tc-99m generator

or

X Other* (specify) Calicheck

B. Sources Used for Instrument Accuracy and Constancy Tests

Radionuclide	Suggested Activity (mCi)	Activity (mCi)	Accuracy
Co-57	3-5	5	± 5%
Ba-133	0.1-0.5	0.250	± 5%
Cs-137	0.1-0.2	0.200	± 5%
Ra-226	1-2		

C. X The procedures described in Section 2 of Appendix D will be used for calibration of the dose calibrator

or

__________ Equivalent procedures are attached.

*For licensees who are not authorized for Mo-99/Tc-99m generators, activity must be equivalent to the highest activity used.

DOSE CALIBRATOR CALIBRATION CERTIFICATE

Calibration Date: ______________________

Facility: ______________________ City: ______________________ State: ________________

Instrument Identification:

Manufacturer: ____________________________ Model No. ____________

Serial No. ________________________________

CALIBRATION DATA

Radionuclide Used	Setting or Module	Actual Activity	Measured Activity	±10%	Correction Factor

COMMENTS

____

____

NEXT CALIBRATION DATE: ____________________________

CALIBRATED BY: ____________________________

CONTROL NO. 3520

FACILITIES AND EQUIPMENT

RADIATION SAFETY EQUIPMENT

Enclosed is the "Nuclear Medical Physics Equipment Requirements" list which details all radiation safety equipment on hand at each imaging center.

STORAGE AND WASTE AREA

The active storage/waste areas are shielded as shown in the enclosed diagram. Once radioactive material is received and opened, according to items 12 and 14 of this application, it will be stored in these areas until used.

Waste is segregated into short and long components and disposed of according to item 18 of this application.

DOSE PREPARATION AREA

All doses are received in unit dose form and stored as noted above. Syringe shields, disposable gloves, absorbant pads, and all other ancillary supplies mentioned on the enclosed list will be on hand in this area and used at each imaging center.

The dose prep area is continually monitored by an area GM monitor. All survey meters are kept in this area for quick use and storage.

SECURITY

We confirm that each imaging-hot lab area will be secured against unauthorized entry by locking the door(s) to these areas.

BY CATAGORY

NUCLEAR MEDICAL PHYSICS EQUIPMENT REQUIREMENTS

ASSAY AND MONITORING DEVICES:

ITEM	CAT #	SUPPLIER
Dose Calibrator	086-307	Atomic Products
Moly Shield	086-423	"
Vial Syringe Holder	086-240	"
Well Insert	086-241	"
Calicheck		Calcorp Corp.
GM Survey Meters (2)	Surveyor 2000	BICRON
GM Probes (2)		"
Room Monitor	05-437	Nuclear Associates
Check Source	62-103	"

RADIOACTIVE SOURCES-STANDARDS

Dose Calibrator Standards	NES-369	New England Nuclear
LFOV Co-57 Flood Source	NES-392	"
Flexible Radioactive Ruler (2)	67-231	Nuclear Associates

SHIELDING

Lead Glass Table Top Shield	TTS-102	ADC
Syringe Shields All-Vue 3cc (2)	56-212	Nuclear Associates
5cc (1)	56-213	"
Syringe Carriers (2)	SC-722	ADC
Clear Pb Storage Cave	56-611	Nuclear Associates
Rad-Waste Container	14-500	"

CAMERA QUALITY CONTROL

High Resolution Bar Pattern	76-815	Nuclear Associates
Caution Signs and Labels:		
Hot Lab	024-914	Atomic Products
Camera Room	024-999	"
Radioactive Materials	028-002	"
Rad Waste Tape (2)	026-012	"
Tape Dispenser	035-100	"

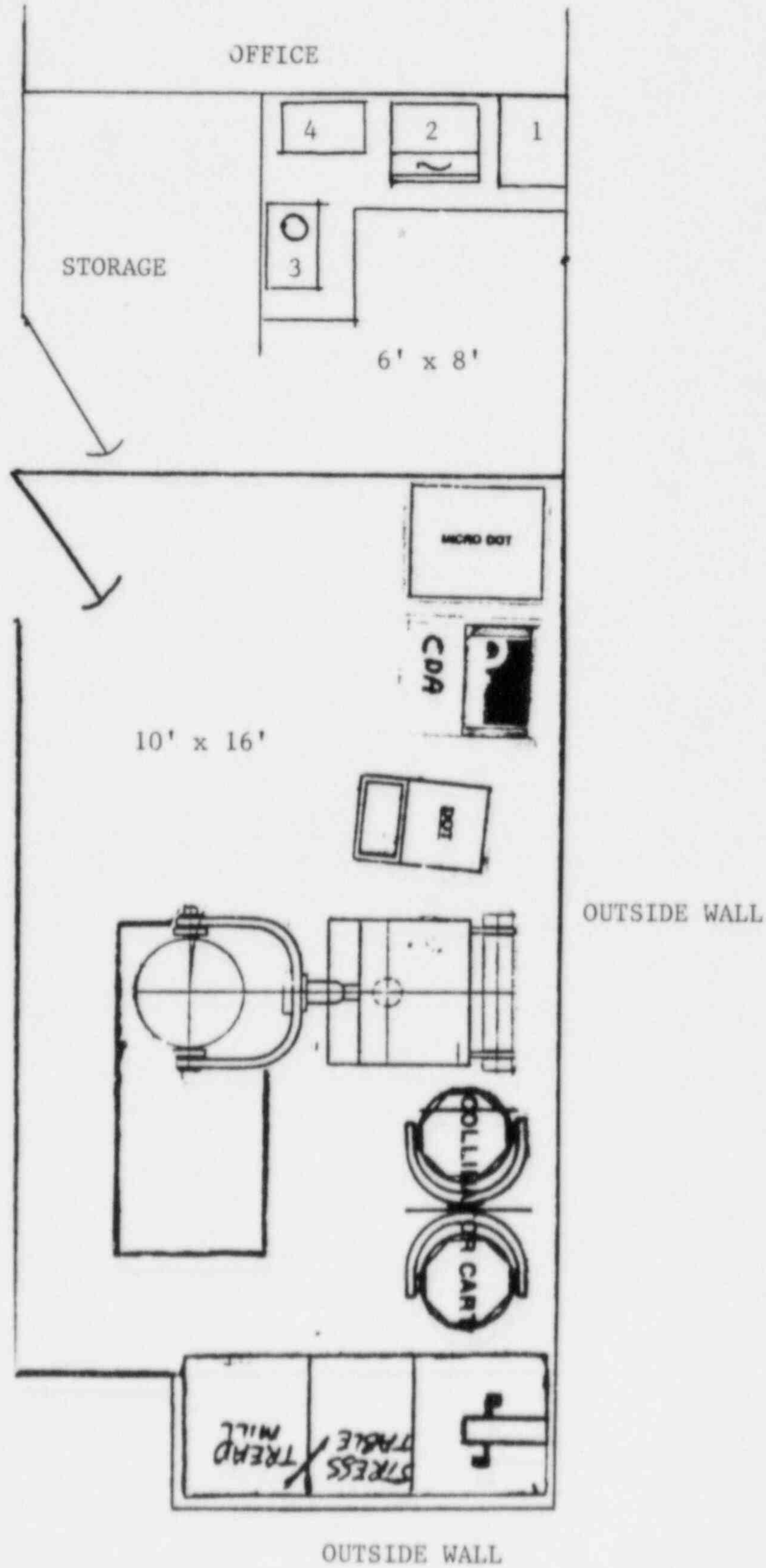
ITEM	CAT #	SUPPLIER
Decontaminating Agents		
Radiacwash (4 gallons)	005-100	Atomic Products
MISCELLANEOUS DISPOSABLE ITEMS		
Plastic Gloves		
Plastic Backed Absorbant Pads		
Plastic Trays		
Remote Handling Tongs		
PERSONNEL MONITORING DEVICES		
Whole Body Film Badge		R. S. Landauer
Ring Badges 2/person		

* A Nuclear Regulatory Commission Materials License is required before purchase.

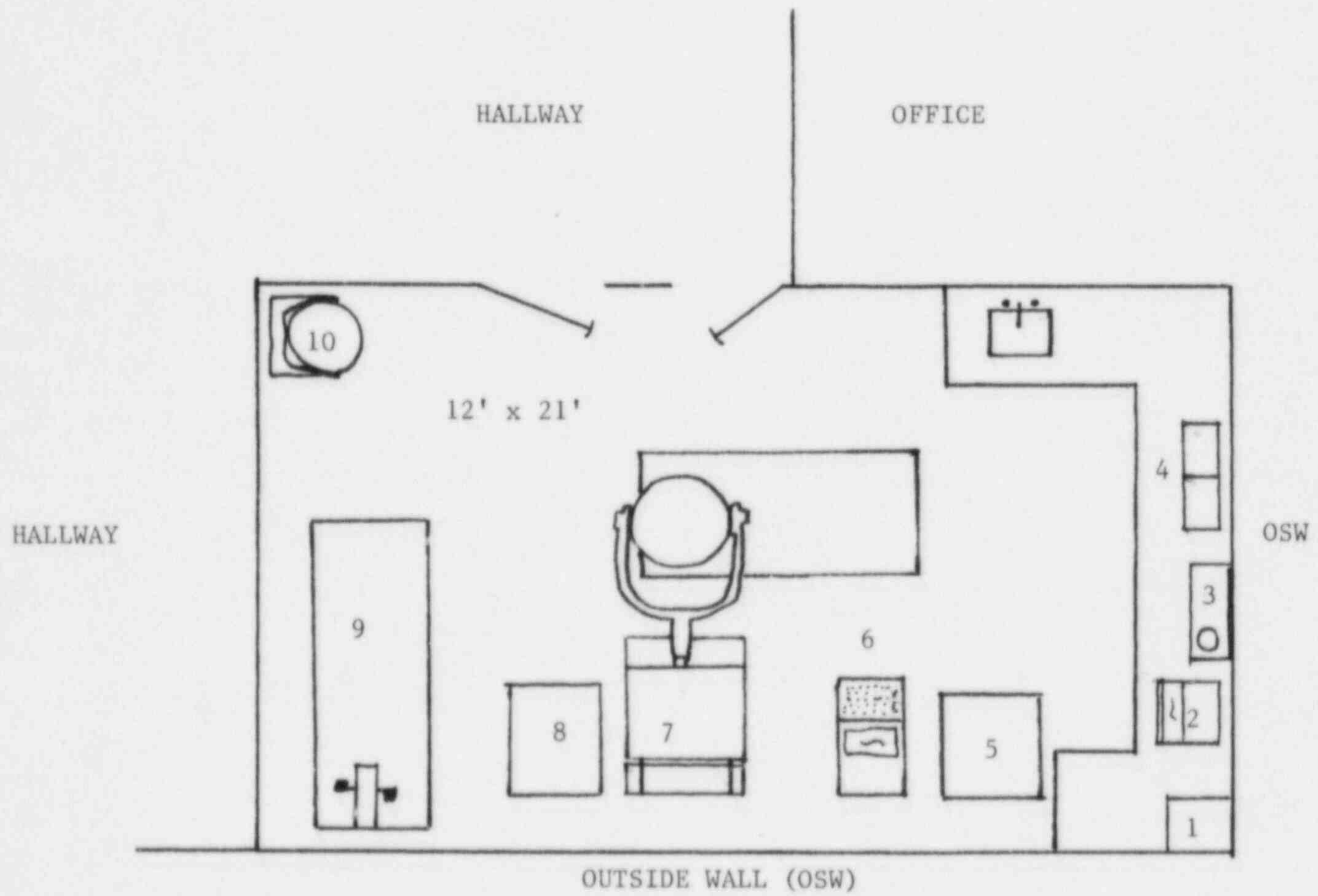
CONTROL NO. 7 8 5 2 0

NUCLEAR & RADIOLOGIC IMAGING PHYSICIANS, P.C.
2151 LIVERNOIS SUITE 201
TROY, MICHIGAN 48083

1. STORAGE/WASTE AREA
2. DOSE PREP AREA
3. DOSE CALIBRATOR
4. SURVEY/AREA METERS



NUCLEAR & RADIOLOGIC IMAGING PHYSICIANS, P.C.
31500 SCHOOLCRAFT
LIVONIA, MI 48150

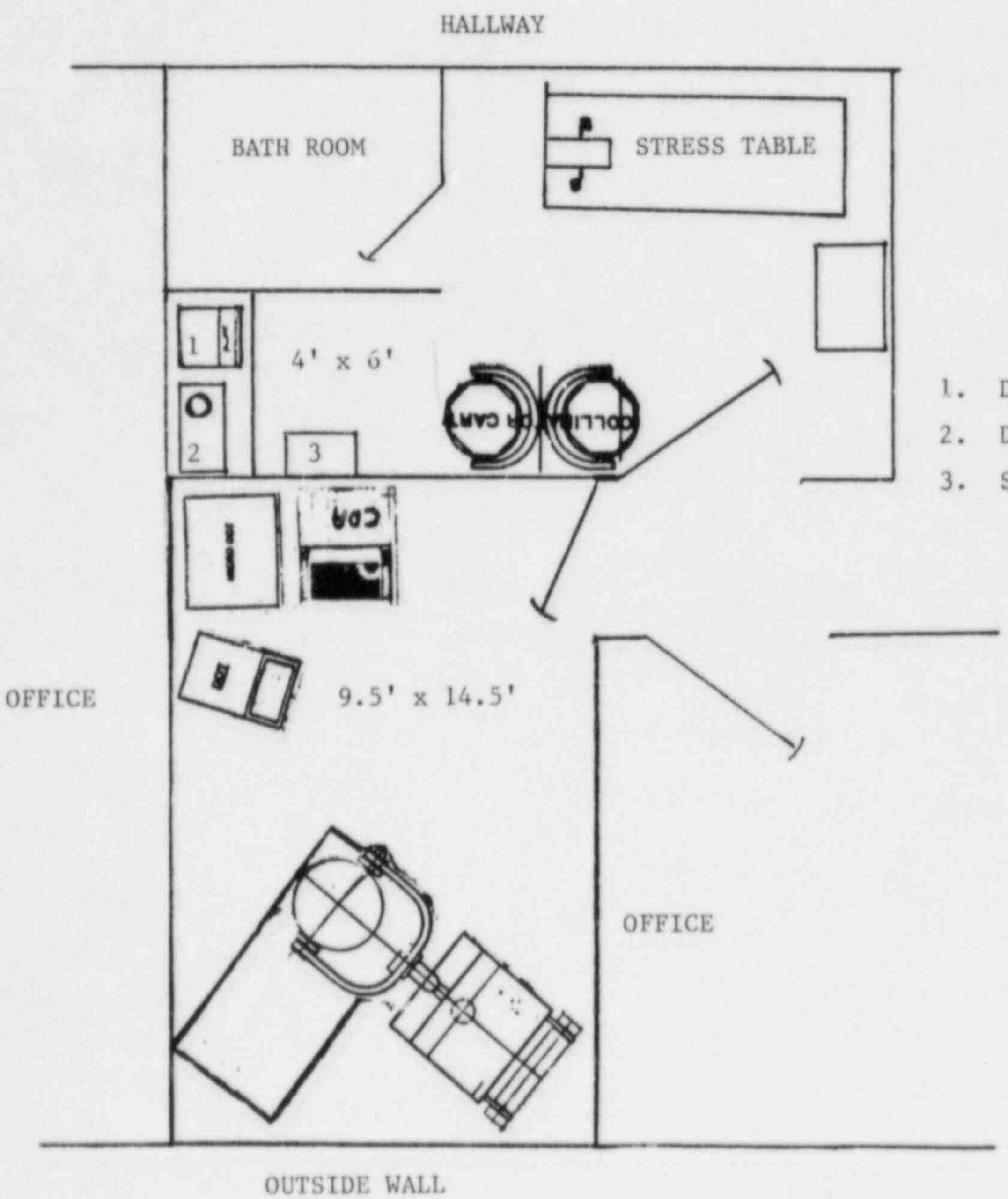


1. STORAGE/WASTE AREA
2. DOSE PREP AREA
3. DOSE CALIBRATOR
4. SURVEY/AREA METERS
5. COMPUTER
6. CAMERA CONSOLE
7. CAMERA
8. ANALOG FORMATTER
9. STRESS TABLE
10. COLLIMATOR CART

NUCLEAR & RADIOLOGIC IMAGING PHYSICIANS, P.C.

FISHER BUILDING SUITE 1073

DETROIT, MI 48202



1. DOSE PREP AREA
2. DOSE CALIBRATOR
3. STORAGE/WASTE AREA

CONTROL NO. 7 8 5 2 0

PERSONNEL TRAINING PROGRAM

Location Nuclear and Radiologic Imaging Physicians, P.C.

"All individuals working in or frequenting any portion of a restricted area shall be kept informed of (radioactive material storage and use, and associated health hazards and applicable regulations)." 10 CFR 19.12

We, the undersigned, have read and understand the attached information concerning safe use of radioactive material and the associated health risks. Additionally, it is our understanding that this program will be reviewed initially and annually thereafter.

Name	Date	Name	Date

RADIATION SAFETY FOR SUPPORT PERSONNEL

The following information is designed to cover areas of radiation safety specifically the concern of support personnel. The areas will include: A) warning signs; B) rules; C) accidents; and D) obligations and rights. Support personnel, as termed, will include security, clerical, maintenance and housekeeping.

Radiation Warning Signs to Recognize

1. Caution Radioactive Materials - This sign warns that you are about to enter an area where radioactive materials are used. Some of your work will take you into these areas. Normally, radioactive materials are stored in containers which prevent the material from escaping. These containers are also labeled with a "Caution Radioactive Materials" sign. Never touch or move these containers.

2. Radioactive: Handle Carefully - This sign warns you that the package contains radioactive material. The package is safe to carry, but must be handled according to the rules of this facility.

3. Caution Radiation Area - Normally, your job will not take you into such an area, but if it does, you must be aware that radiation above normal levels is present.

Remember the general rule, "the more the radiation, the greater the hazard". The risk of harm increases as you spend more time exposed to the radiation. Therefore, if your job requires you to enter a radiation area, do your job quickly so you will receive as little radiation expsoure as possible.

Radiation Safety Rules to Follow

1. Clerical Staff - When your job requires you to enter the Nuclear Medicine Department, use the following radiation safety rules:

   A. Note warning signs.

   B. Open door carefully, to avoid collisions.

   C. Do not proceed without permission, into work area.

   D. If you are or may be pregnant, you should not work in the Nuclear Medicine Department.

2. Maintenance - When your work requires you to enter the Nuclear Medicine Department, use the following radiation safety rules to avoid contact with radio--active materials:

   A. Note warning signs.

   B. Open door carefully, to avoid collisions.

   C. Check for technologists, once inside.

   D. Check for radioactive materials. If you find radioactive materials near the place where you are to work either notify the technologist if present, or leave and find the technologist. Have the technologist move the radioactive container away from your work area.

   E. If you are or may be pregnant, you should not work in the Nuclear Medicine Department.

   F. If for any reason you work in the Nuclear Medicine Department outside of regular business hours, do not leave the door unlocked if you leave the area temporarily. Be sure the door is locked upon completion of your work.

3. Housekeeping - When your work requires you to enter the Nuclear Medicine Department, use the following radiation safety rules:

   A. Note warning signs.

   B. Do not empty any "Caution Radioactive Waste" baskets or containers. Radioactive waste is not mixed with reqular trash. The technologist will take care of it's removal.

   C. Do not clean or disturb any equipment on tops of lab tables. This applies especially to the "hot lab".

   D. Work at brisk, safe pace. Spend as little time as possible in a room containing radioactive materials. When break time comes, remember that a Nuclear Medicine Department is no place to eat, smoke, or relax.

E. If you are or may be pregnant, you should not work or clean in the Nuclear Medicine Department.

F. If for any reason you work in the Nuclear Medicine Department outside of regular business hours, do not leave the door unlocked if you leave the area temporarily. Be sure the door is locked upon completion of your work.

How to Handle an Accident Involving a Radioactive Spill

1. Keep away. Do not approach the radioactive materials spill.

2. Leave at once. Leave the area immediately and lock the door.

3. Call the Radiation Safety Officer. If the radioactive spill takes place during Nuclear Medicine personnel off-duty hours, notify the Radiation Safety Officer immediately about the accident.

Safety Obligations and Rights

Each worker has an obligation to follow radiation safety rules. It is an important part of your job to be on the watch for unsafe situations and know how to react in case of a radiation accident.

As a worker, you also have a right by law to ask questions and seek advice about radiation and safety. In almost all cases, the Radiation Safety Officer or some other staff member will be able to answer any questions you may have. However, if you still need more information, you also have the right to talk with state and even federal authorities.

U.S. NUCLEAR REGULATORY COMMISSION July 1981

REGULATORY GUIDE

OFFICE OF NUCLEAR REGULATORY RESEARCH

REGULATORY GUIDE 8.29
(Task OH 902-4)

INSTRUCTION CONCERNING RISKS FROM OCCUPATIONAL RADIATION EXPOSURE

A. INTRODUCTION

Section 19.12 of 10 CFR Part 19, "Notices, Instructions and Reports to Workers; Inspections," requires that all persons working in or frequenting any portion of a restricted area be instructed in the health protection problems associated with exposure to radioactive materials or radiation. This guide describes the instruction that should be provided to the worker concerning biological risks from occupational radiation exposure. Additional guides are being or will be developed to address other aspects of radiation protection training.

B. DISCUSSION

It is generally accepted by the scientific community that exposure to ionizing radiation can cause biological effects that are harmful to the exposed organism. These effects are classified into three categories:

Somatic Effects: Effects occurring in the exposed person that, in turn, may be divided into two classes:

Prompt effects that are observable soon after a large or acute dose (e.g., 100 rems[1] or more to the whole body in a few hours), and

Delayed effects such as cancer that may occur years after exposure to radiation.

Genetic Effects:[2] Abnormalities that may occur in the future children of exposed individuals and in subsequent generations.

Teratogenic Effects: Effects that may be observed in children who were exposed during the fetal and embryonic stages of development.

Concerns about these biological effects have resulted in controls on doses to individual workers and in efforts to control the collective dose (person-rems) to the worker population.

NRC-licensed activities result in a significant fraction of the total occupational radiation exposure in the United States. Regulatory action has recently focused more attention on maintaining occupational radiation exposure at levels that are as low as is reasonably achievable (ALARA). Radiation protection training for all workers who may be exposed to ionizing radiation is an essential component of any program designed to maintain exposure levels ALARA. A clear understanding of what is presently known about the biological risks associated with exposure to radiation will result in more effective radiation protection training and should generate more interest on the part of the worker in minimizing both individual and collective doses. In addition, radiation workers have the right to whatever information on radiation risk is available to enable them to make informed decisions regarding the acceptance of these risks. It is intended that workers who receive this instruction develop a healthy respect for the risks involved rather than excessive fear or indifference.

At the relatively low levels of occupational radiation exposure in the United States, it is difficult to demonstrate a relationship between exposure and effect. There is considerable uncertainty and controversy regarding estimates of radiation risk. In the appendix to this guide, a range of risk estimates is provided (see Table 1). Information on radiation risk has been included from such sources as the 1980 National Academy of Sciences' Report of the Committee on the Biological Effects of Ionizing Radiation (BEIR-80), the International Commission on Radiological Protection (ICRP) Publication 27 entitled "Problems in Developing an Index of Harm," the 1979 report of the science work group of the Interagency Task Force on the Health Effects of Ionizing Radiation, the 1977 report of the United Nations Scientific Committee on the Effects of Atomic Radiation (UNSCEAR report), and numerous published articles (see the bibliography to the appendix).

[1] In the International System of Units (SI), the rem is replaced by the sievert. 100 rems is equal to 1 sievert (Sv).

[2] Genetic effects exceeding normal incidence have not been observed in any of the studies of exposed humans.

C. REGULATORY POSITION

Strong management support is considered essential to an adequate radiation protection training program. Instruction to workers performed in compliance with §19.12 of 10 CFR Part 19 should be given prior to assignment to work in a restricted area and periodically thereafter. In providing instruction concerning health protection problems associated with exposure to radiation, all workers, including those in supervisory roles, should be given specific instruction on the risk of biological effects resulting from exposure to radiation.

The instruction should be presented both orally and in printed form to all affected workers and supervisors. It should include the information provided in the appendix to this guide.[3] The information should be discussed during training sessions. Each individual should be given an opportunity to ask questions and should be asked to acknowledge in writing that the instruction has been received and understood.

[3]Copies of the appendix to this guide are available at the current Government Printing Office price, which may be obtained by writing to the U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, Attention: Publications Sales Manager. This appendix is not copyrighted, and Commission approval is not required to reproduce it.

D. IMPLEMENTATION

The purpose of this section is to provide information to applicants regarding the NRC staff's plans for using this regulatory guide.

Except in those cases in which an applicant or licensee proposes an acceptable alternative method for complying with specified portions of the Commission's regulations, the methods described in this guide will be used in the evaluation of the training program for all individuals working in or frequenting any portion of a restricted area and for all supervisory personnel after December 15, 1981.

If an applicant or licensee wishes to use the material provided in this guide on or before December 15, 1981, the pertinent portions of the application or the licensee's performance will be evaluated on the basis of this guide.

U.S. NUCLEAR REGULATORY COMMISSION

APPENDIX TO REGULATORY GUIDE 8.29

INSTRUCTION CONCERNING RISKS FROM OCCUPATIONAL RADIATION EXPOSURE

This instructional material is intended to provide the user with the best available information concerning what is currently known about the health risks from exposure to ionizing radiation.[1] A question and answer format has been used. The questions were developed by the NRC staff in consultation with workers, union representatives, and licensee representatives experienced in radiation protection training. Risk estimates have been compiled from numerous sources generally recognized as reliable. A bibliography is included for the user interested in further study.

The biological effects that are known to occur after exposure to high doses (hundreds of rems[2]) of radiation are discussed early in the document; discussions of the estimated risks from the low occupational dose (<5 rems per year) follow. It is intended that this information will help develop an attitude of healthy respect for the risks associated with radiation, rather than unnecessary fear or lack of concern. Additional guidance is being or will be developed concerning other topics in radiation protection training.

• • • • • • •

1. *What is meant by risk?*

Risk can be defined in general as the probability (chance) of injury, illness, or death resulting from some activity. However, the perception of risk is affected by how the individual views its probability and its severity. The intent of this document is to provide estimates of and explain the basis for possible risk of injury, illness, or death resulting from occupational radiation exposure. (See Questions 9 and 10 for estimates of radiation risk and comparisons with other types of risk.)

2. *What are the possible health effects of exposure to radiation?*

Some of the health effects that exposure to radiation may cause are cancer (including leukemia), birth defects in the future children of exposed parents, and cataracts.[3] These effects (with the exception of genetic effects) have been observed in studies of medical radiologists, uranium miners, radium workers, and radiotherapy patients who have received large doses of radiation. Studies of people exposed to radiation from atomic weapons have also provided data on radiation effects. In addition, radiation effects studies with laboratory animals have provided a large body of data on radiation-induced health effects, including genetic effects.

The observations and studies mentioned above, however, involve levels of radiation exposure that are much higher (hundreds of rems) than those permitted occupationally today (<5 rems per year). Although studies have not shown a cause-effect relationship between health effects and current levels of occupational radiation exposure, it is prudent to assume that some health effects do occur at the lower exposure levels.

3. *What is meant by prompt effects, delayed effects, and genetic effects?*

a. Prompt effects are observable shortly after receiving a very large dose in a short period of time. For example, a whole-body[4] dose of 450 rems (90 times the annual dose limit for routine occupational exposure) in an hour to an average adult will cause vomiting and diarrhea within a few hours; loss of hair, fever, and weight loss within a few weeks; and about a 50 percent chance of death within 60 days without medical treatment.

b. Delayed effects such as cancer may occur years after exposure to radiation.

c. Genetic effects can occur when there is radiation damage to the genetic material. These effects may show up as birth defects or other conditions in the future children of the exposed individual and succeeding generations, as demonstrated in animal experiments. However, excess genetic effects clearly caused by radiation have not been observed in human populations exposed to radiation. It has been observed, however, that radiation can change the genes in cells of the human body. Thus, the possibility exists that genetic effects can be caused in humans by low doses even though no direct evidence exists as yet.

4. *In worker protection, which effects are of most concern to the NRC?*

The main concern to the NRC is the delayed incidence of cancer. The chance of delayed cancer is believed to depend

[1]Ionizing radiation consists of energy or small particles such as gamma, beta, or alpha radiation emitted from radioactive materials which, when absorbed by living tissue, can cause chemical and physical damage.

[2]The rem is the unit of measure for radiation dose and relates to the biological effect of the absorbed radiation.

[3]Cataracts differ from other radiation effects in that a certain level of dose to the lens of the eye (~200 rems) is required before they are observed.

[4]It is important to distinguish between whole-body and partial-body exposure. 100 rems to the whole body will have more effect than 100 to a hand. For example, exposure of a hand would affect a small fraction of the bone marrow and a limited portion of the skin.

on how much radiation exposure a person gets; therefore, every reasonable effort should be made to keep exposures low.

Immediate or prompt effects are very unlikely since large exposures would normally occur only if there were a serious radiation accident. Accident rates in the radiation industry have been low, and only a few accidents have resulted in exposures exceeding the legal limits. The probability of serious genetic effects in the future children of workers is estimated in the BEIR[5] report, based on animal studies, at less than one-third that of delayed cancer (5-65 genetic effects per million rems compared to 160-450 cancer cases). A clearer understanding of the cause-effect relationship between radiation and human genetic effects will not be possible until additional research studies are completed.

5. *What is the difference between acute and chronic exposure?*

Acute radiation exposure, which causes prompt effects and may also cause delayed effects, usually refers to a large dose of radiation received in a short period of time; for example, 450 rems received within a few hours or less. The effects of acute exposures are well known from studies of radiotherapy patients, some of whom received whole-body doses; atomic bomb victims; and the few accidents that have occurred in the early days of atomic weapons and reactor development, industrial radiography, and nuclear fuel processing. There have been few occupational incidents that have resulted in large exposures. NRC data indicate that, on the average, 1 accidental overexposure in which any acute symptoms are observed occurs each year. Most of these occur in industrial radiography and involve exposures of the hands rather than the whole body.

Chronic exposure, which may cause delayed effects but not prompt effects, refers to small doses received repeatedly over long time periods; for example, 20-100 mrem (a mrem is one-thousandth of a rem) per week every week for several years. Concern with occupational radiation risk is primarily focused on chronic exposure to low levels of radiation over long time periods.

6. *How does radiation cause cancer?*

How radiation causes cancer is not well understood. It is impossible to tell whether a given cancer was caused by radiation or by some other of the many apparent causes. However, most diseases are caused by the interaction of several factors. General physical condition, inherited traits, age, sex, and exposure to other cancer-causing agents such as cigarette smoke are a few possible contributing factors. One theory is that radiation can damage chromosomes in a cell, and the cell is then directed along abnormal growth patterns. Another is that radiation reduces the body's normal resistance to existing viruses which can then multiply and damage cells. A third is that radiation activates an existing virus in the body which then attacks normal cells causing them to grow rapidly.

What is known is that, in groups of highly exposed people, a higher than normal incidence of cancer is observed. Higher than normal rates of cancer can also be produced in laboratory animals by high levels of radiation. An increased incidence of cancer has not been demonstrated at radiation levels below the NRC limits.

7. *If I receive a radiation dose, does that mean I am certain to get cancer?*

Not at all. Everyone gets a radiation dose every day (see Question 25), but most people do not get cancer. Even with doses of radiation far above legal limits, most individuals will experience no delayed consequences. There is evidence that some radiation damage can be repaired. The danger from radiation is much like the danger from cigarette smoke. Only a fraction of the people who breathe cigarette smoke get lung cancer, but there is good evidence that smoking increases a person's chances of getting lung cancer. Similarly, there is evidence that the larger the radiation dose, the larger the increase in a person's chances of getting cancer.

Radiation is like most substances that cause cancer in that the effects can be seen clearly only at high doses. Estimates of the risks of cancer at low levels of exposure are derived from data available for exposures at high dose levels and high dose rates. Generally, for radiation protection purposes these estimates are made using the linear model (Curve 1 in Figure 1). We have data on health effects at high doses as shown by the solid line in Figure 1. Below about 100 rems, studies have not been able to accurately measure the risk, primarily because of the small numbers of exposed people and because the effect is small compared to differences in the normal incidence from year to year and place to place. Most scientists believe that there is some degree of risk no matter how small the dose (Curves 1 and 2). Some scientists believe that the risk drops off to zero at some low dose (Curve 3), the threshold effect. A few believe that risk levels off so that even very small doses imply a significant risk (Curve 4). The majority of scientists today endorse either the linear model (Curve 1) or the linear-quadratic model (Curve 2). The NRC endorses the linear model (Curve 1), which shows the number of effects decreasing as the dose decreases, for radiation protection purposes.

It is prudent to assume that smaller doses have some chance of causing cancer. This is as true for natural cancer-causers such as sunlight and natural radiation as it is for those that are man made such as cigarette smoke, smog, and man-made radiation. As even very small doses may entail some small risk, it follows that no dose should be taken without a reason. Thus, a principle of radiation protection is to do more than merely meet the allowed regulatory

[5]The National Academy of Sciences established a committee on the Biological Effects of Ionizing Radiation (BEIR) whose 1980 report on the effects on populations of exposure to low levels of ionizing radiation provides much of the background for this guide.

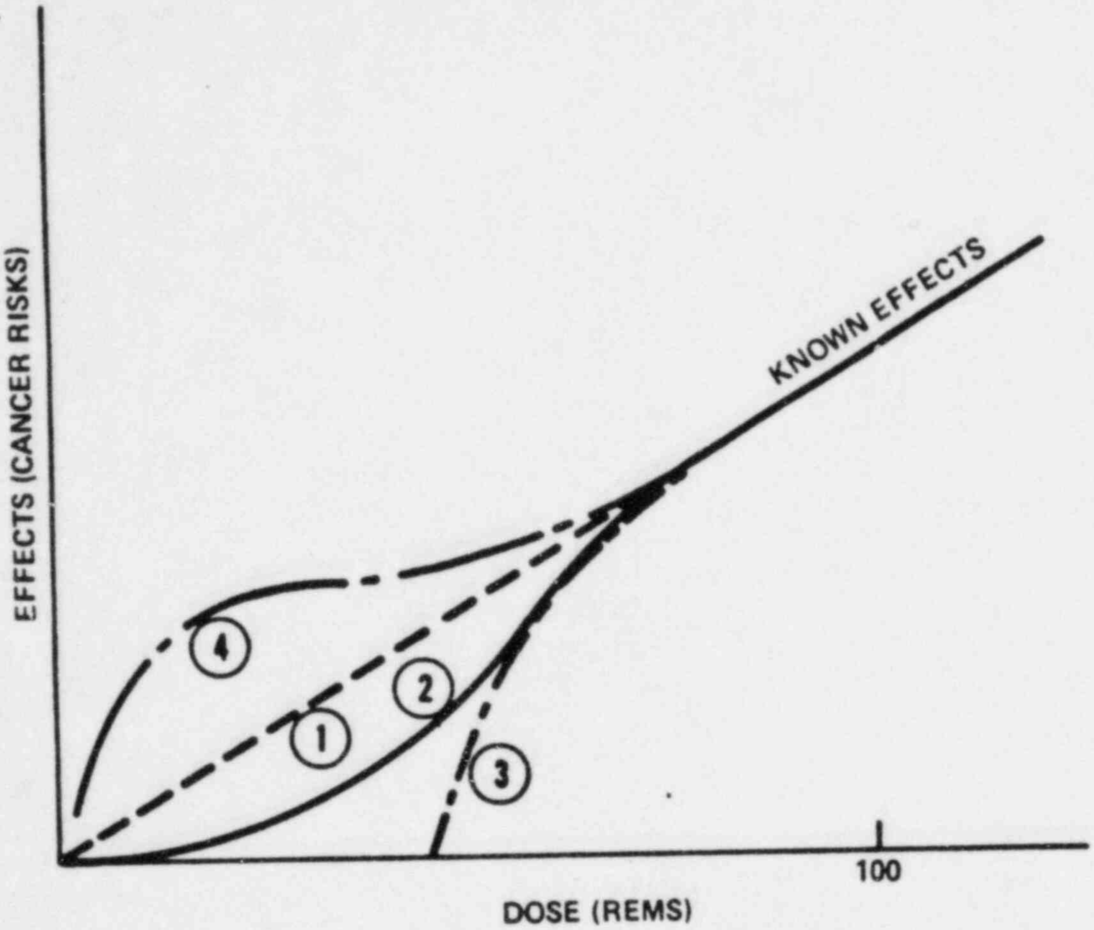


Figure 1. Some proposed models for how the effects of radiation vary with doses at low levels.

limits; doses should be kept as low as is reasonably achievable (ALARA).

We don't know exactly what the chances are of getting cancer from a low-level radiation dose, but we can make estimates based on extensive scientific knowledge. The estimates of radiation risks are at least as reliable as estimates for the effects from any chemical hazard. Being exposed to typical occupational radiation doses is taking a chance, but that chance is reasonably well understood.

It is important to understand the probability factors here. A similar question would be: If you select one card from a full deck, will you get the ace of spades? This question cannot be answered with a simple yes or no. The best answer is that your chances are 1 in 52. However, if 1000 people each select one card from full decks, we can predict that about 20 of them will get an ace of spades. Each person will have 1 chance in 52 of drawing the ace of spades, but there is no way that we can predict which persons will get the right card. The issue is further complicated by the fact that in 1 drawing by 1000 people, we might get only 15 successes and in another perhaps 25 correct cards in 1000 draws. We can say that if you receive a radiation dose, you will have increased your chances of eventually developing cancer. It is assumed that the more radiation exposure you get, the more you increase your chances of cancer.

Not all workers incur the same level of risk. The radiation risk incurred by a worker depends on the amount of dose received. Under the linear model explained above, a worker who receives 5 rems in a year incurs 10 times as much risk as another worker (the same age) who receives only 0.5 rem. The risk depends not only on the amount of dose, but also on the age of the worker at the time the dose is received. This age difference is due, in part, to the fact that a young worker has more time to live than an older worker, and the risk is believed to depend on the number of years of life following the dose. The more years left, the larger the risk. It should be clear that, even within the regulatory dose limits, the risk may vary a great deal from one worker to another. Fortunately, only a very few workers receive doses near 5 rems per year; as pointed out in the answer to Question 19, the average annual dose for all radiation workers is less than 0.5 rem.

A reasonable comparison involves exposure to the sun's rays. Frequent short exposures provide time for the skin to repair. An acute exposure to the sun can result in painful burning, and excessive exposure has been shown to cause skin cancer. However, whether exposure to the sun's rays is short term or spread over time, some of the injury is not repaired and may eventually result in skin cancer.

The effect upon a group of workers occupationally exposed to radiation may be an increased incidence of cancer over and above the number of cancers that would normally be expected in that group. Each exposed individual has an increased probability of incurring subsequent cancer. We can say that if 10,000 workers each receive an additional 1 rem in a year, that group is more likely to have a larger incidence of cancer than 10,000 people who do not receive the additional radiation. An estimate of the increased probability of cancer from low radiation doses delivered to large groups is one measure of occupational risk and is discussed in Question 9.

8. *What groups of expert scientists have studied the risk from exposure to radiation?*

In 1956, the National Academy of Sciences established advisory committees to consider radiation risks. The first of these was the Advisory Committee on the Biological Effects of Atomic Radiations (BEAR) and more recently it was renamed the Advisory Committee on the Biological Effects of Ionizing Radiation (BEIR). These committees have periodically reviewed the extensive research being done on the health effects of ionizing radiation and have published estimates of the risk of cancer from exposure to radiation (1972 and 1980 BEIR reports). The International Commission on Radiological Protection (ICRP) and the National Council on Radiation Protection and Measurement (NCRP) are two other groups of scientists who have studied radiation effects and published risk estimates (ICRP Publication 26, 1977). These two groups have no government affiliation. In addition, the United Nations established an independent study group that published an extensive report in 1977, including estimates of cancer risk from ionizing radiation (UNSCEAR, 1977).

Several individual research groups or scientists such as Alice Stewart, E.S. Gilbert, T.F. Mancuso, T.W. Anderson, to name a few, have published studies concerning low-level radiation effects. The bibliography to this appendix includes several articles for the reader who wishes to do further study. The BEIR-80 report includes analysis of the work of many independent researchers.

9. *What are the estimates of the risk of cancer from radiation exposure?*

The cancer risk estimates (developed by the organizations identified in Question 8) are presented in Table 1.

In an effort to explain the significance of these estimates, we will use an approximate average of 300 excess cancer cases per million people, each exposed to 1 rem of ionizing radiation. If in a group of 10,000 workers each receives 1 rem, we could estimate that three would develop cancer because of that exposure, although the actual number could be more or less than three.

TABLE 1

Estimates of Excess Cancer Incidence from Exposure to Low-Level Radiation

Source	Number of Additional[a] Cancers Estimated to Occur in 1 Million People After Exposure of Each to 1 Rem of Radiation
BEIR, 1980	160-450[b]
ICRP, 1977	200
UNSCEAR, 1977	150-350

[a]Additional means above the normal incidence of cancer.

[b]All three groups estimated premature deaths from radiation-induced cancers. The American Cancer Society has recently stated that only about one-half of all cancer cases are fatal. Thus, to estimate incidence of cancer, the published numbers were multiplied by 2. Note that the three groups are in close agreement on the risk of radiation-induced cancer.

The American Cancer Society has reported that approximately 25 percent of all adults in the 20- to 65-year age bracket will develop cancer at some time from all possible causes such as smoking, food, alcohol, drugs, air pollutants, and natural background radiation. Thus in any group of 10,000 workers not exposed to radiation on the job, we can expect about 2,500 to develop cancer. If this entire group of 10,000 workers were to receive an occupational radiation dose of 1 rem each, we could estimate that three additional cases might occur which would give a total of about 2,503. This means that a 1-rem dose to each of 10,000 workers might increase the cancer rate from 25 percent to 25.03 percent, an increase of about 3 hundredths of one percent.

As an individual, if your cumulative occupational radiation dose is 1 rem, your chances of eventually developing cancer during your entire lifetime may have increased from 25 percent to 25.03 percent. If your lifetime occupational dose is 10 rems, we could estimate a 25.3 percent chance of developing cancer. Using a simple linear model, a lifetime dose of 100 rems may have increased your chances of cancer from 25 to 28 percent.

The normal chance of developing cancer if you receive no occupational radiation dose is about equal to your chance of getting any spade on a single draw from a full deck of playing cards, which is one chance out of four. The additional chance of developing cancer from an occupational exposure of 1 rem is less than your chances of drawing an ace from a full deck of cards three times in a row.

Since cancer resulting from exposure to radiation usually occurs 5 to 25 years after the exposure and since not all cancers are fatal, another useful measure of risk is years of life expectancy lost on the average from a radiation-induced cancer. It has been estimated in several studies that the average loss of life expectancy from exposure to radiation is about 1 day per rem of exposure. In other words, a person exposed to 1 rem of radiation may, on the average, lose 1 day of life. The words "on the average" are important, however, because the person who gets cancer from radiation may lose several years of life expectancy while his coworkers suffer no loss. The ICRP estimated that the average number of years of life lost from fatal industrial accidents is 30 while the average number of years of life lost from a fatal radiation-induced cancer is 10. The shorter loss of life expectancy is due to the delayed onset of cancer.

It is important to realize that these risk numbers are only estimates. Many difficulties are involved in designing research studies that can accurately measure the small increases in cancer cases due to low exposures to radiation as compared to the normal rate of cancer. There is still uncertainty and a great deal of controversy with regard to estimates of radiation risk. The numbers used here result from studies involving high doses and high dose rates, and they may not apply to doses at the lower occupational levels of exposure. The NRC and other agencies both in the United States and abroad are continuing extensive long-range research programs on radiation risk.

Some members of the National Academy of Sciences BEIR Advisory Committee and others feel that risk estimates in Table 1 are higher than would actually occur and represent an upper limit on the risk. Other scientists believe that the estimates are low and that the risk could be higher. However, these estimates are considered by the NRC staff to be the best available that the worker can use to make an informed decision concerning acceptance of the risks associated with exposure to radiation. A worker who decides to accept this risk should make every effort to keep exposure to radiation ALARA to avoid unnecessary risk. The worker, after all, has the first line responsibility for protecting himself from radiation hazards.

10. How can we compare radiation risk to other kinds of health risks?

Perhaps the most useful unit for comparison among health risks is the average number of days of life expectancy lost per unit of exposure to each particular health risk. Estimates are calculated by looking at a large number of persons, recording the age when death occurs from apparent causes, and estimating the number of days of life lost as a result of these early deaths. The total number of days of life lost is then averaged over the total group observed.

Several studies have compared the projected loss of life expectancy resulting from exposure to radiation with other health risks. Some representative numbers are presented in Table 2.

These estimates indicate that the health risks from occupational radiation exposure are smaller than the risks associated with many other events or activities we encounter and accept in normal day-to-day activities.

TABLE 2

Estimated Loss of Life Expectancy from Health Risks[a]

Health Risk	Estimates of Days of Life Expectancy Lost, Average
Smoking 20 cigarettes/day	2370 (6.5 years)
Overweight (by 20%)	985 (2.7 years)
All accidents combined	435 (1.2 years)
Auto accidents	200
Alcohol consumption (U.S. average)	130
Home accidents	95
Drowning	41
Natural background radiation, calculated	8
Medical diagnostic x-rays (U.S. average), calculated	6
All catastrophes (earthquake, etc.)	3.5
1 rem occupational radiation dose, calculated (industry average for the higher-dose job categories is 0.65 rem/yr)	1.
1 rem/yr for 30 years, calculated	30

[a] Adapted from Cohen and Lee, "A Catalogue of Risks," *Health Physics*, Vol. 36, June 1979.

A second useful comparison is to look at estimates of the average number of days of life expectancy lost from exposure to radiation and from common industrial accidents at radiation-related facilities and to compare this number with days lost from other occupational accidents. Table 3 shows average days of life expectancy lost as a result of fatal work-related accidents. Note that the data for occupations other than radiation related do not include death risks from other possible hazards such as exposure to toxic chemicals, dusts, or unusual temperatures. Note also that the unlikely occupational exposure at 5 rems per year for 50 years, the maximum allowable risk level, may result in a risk comparable to the average risks in mining and heavy construction.

Industrial accident rates in the nuclear industry and related occupational areas have been relatively low during the entire history of the industry (see Table 4). This is believed to be due to the early and continuing emphasis on tight safety controls. The relative safety of various occupational areas can be seen by comparing the probability of death by accident per 10,000 workers over a 40-year working lifetime. These figures do not include death from possible causes such as exposure to toxic chemicals or radiation.

11. Can a worker become sterile or impotent from occupational radiation exposure?

Observation of radiation therapy patients who receive localized exposures, usually spread over a few weeks, has

TABLE 3

Estimated Loss of Life Expectancy from Industrial Hazards[a]

Industry Type	Estimates of Days of Life Expectancy Lost, Average
All industry	74
Trade	30
Manufacturing	43
Service	47
Government	55
Transportation and utilities	164
Agriculture	277
Construction	302
Mining and quarrying	328
Radiation accidents, death from exposure	<1
Radiation dose of 0.65 rem/yr (industry average) for 30 years, calculated	20
Radiation dose of 5 rems/yr for 50 years	250
Industrial accidents at nuclear facilities (nonradiation)	58

[a]Adapted from Cohen and Lee, "A Catalogue of Risk," *Health Physics*, Vol. 36, June 1979; and World Health Organization, *Health Implications of Nuclear Power Production*, December 1975.

TABLE 4

Probability of Accidental Death by Type of Occupation[a]

Occupation	Number of Accidental Deaths for 10,000 Workers for 40 Years
Mining	252
Construction	228
Agriculture	216
Transportation and public utilities	116
All industries	56
Government	44
Nuclear industry (1975 data excluding construction)	40
Manufacturing	36
Services	28
Wholesale and trade	24

[a]Adapted from National Safety Council, *Accident Facts*, 1979; and Atomic Energy Commission, *Operational Accidents and Radiation Exposure Experience*, WASH-1192, 1975.

shown that a dose of 500-800 rems to the gonads can produce permanent sterility in males or females (an acute whole-body dose of this magnitude would probably result in death within 60 days). An acute dose of 20 rems to the testes can result in a measurable but temporary reduction in sperm count. Such high exposures on the job could result only from serious and unlikely radiation accidents. Although high doses of radiation can affect fertility, they have no effect on the ability to function sexually. Likewise, exposure to permitted occupational levels of radiation has no observed effect on fertility and also has no effect on the ability to function sexually.

12. What are the NRC external radiation dose limits?

Federal regulations currently limit occupational external whole-body radiation dose to 1¼ rems in any calendar quarter or specified 3-month period. However, when there is documented evidence that a worker's previous occupational dose is low enough, a licensee may permit a dose of up to 3 rems per quarter or 12 rems per year. The accumulated dose may not exceed 5(N - 18) rems[6] where N is the person's age in years, i.e., the lifetime occupational dose may not exceed an average of 5 rems for each year above the age of 18.

An additional whole-body dose of approximately 5 rems per year is permitted from internal exposure. (See Question 28.)

13. What is meant by ALARA?

In addition to providing an upper limit on a person's permissible radiation exposure, the NRC also requires that its licensees maintain occupational exposures as far below the limit as is reasonably achievable (ALARA). This means that every activity at a nuclear facility involving exposure to radiation should be planned so as to minimize unnecessary exposure to individual workers and also to the worker population. A job that involves exposure to radiation should be scheduled only when it is clear that the benefit justifies the risks assumed. All design, construction, and operating procedures should be reviewed with the objective of reducing unnecessary exposures.

14. Has the ALARA concept been applied if, instead of reaching dose limits during the first week of a quarter, the worker's dose is spread out over the whole quarter?

No. For radiation protection purposes, the risk of cancer from low doses is assumed to be proportional to the amount of exposure, not the rate at which it is received. Thus it is assumed that spreading the dose out over time or over larger numbers of people does not reduce the overall risk. The ALARA concept has been followed only when the individual and collective doses are reduced by reducing the time of exposure or decreasing radiation levels in the

[6]The NRC has published a proposed rule change for public comment that would eliminate the 5(N-18) formula. This proposal is currently under consideration by a task force reviewing all of 10 CFR Part 20. Recent EPA guidance recommends eliminating the 5(N-18) formula. If adopted, the maximum allowed annual dose will be 5 rems rather than 12.

individual and collective doses are reduced by reducing the time of exposure or decreasing radiation levels in the working environment.

15. What is meant by collective dose and why should it be maintained ALARA?

Nuclear industry activities expose an increasing number of people to occupational radiation in addition to the radiation doses they receive from natural background radiation and medical radiation exposures. The collective occupational dose (person-rems) is the sum of all occupational radiation exposure received by all the workers in an entire worker population. For example, if 100 workers each receive 2 rems, the individual dose is 2 rems and the collective dose is 200 person-rems. The total additional risk of cancer and genetic effects in an exposed population is assumed to depend on the collective dose.

It should be noted that, from the viewpoint of risk to a total population, it is the collective dose that must be controlled. For a given collective dose, the number of health effects is assumed to be the same even if a larger number of people share the dose. Therefore, spreading the dose out may reduce the individual risk, but not that of the population.

Efforts should be made to maintain the collective dose ALARA so as not to unnecessarily increase the overall population incidence of cancer and genetic effects.

16. Is the use of extra workers a good way to reduce risks?

There is a "yes" answer to this question and a "no" answer. For a given job involving exposure to radiation, the more people who share the work, the lower the average dose to an individual. The lower the dose, the lower the risk. So, for you as an individual, the answer is "yes."

But how about the risk to the entire group of workers? Under assumptions used by the NRC for purposes of protection, the risk of cancer depends on the total amount of radiation energy absorbed by human tissue, not on the number of people to whom this tissue belongs. Therefore, if 30 workers are used to do a job instead of 10, and if both groups get the same collective dose (person-rems), the total cancer risk is the same, and nothing was gained for the group by using 30 workers. From this viewpoint the answer is "no." The risk was not reduced but simply spread around among a larger number of persons.

Unfortunately, spreading the risk around often results in a larger collective dose for the job. Workers are exposed as they approach a job, while they are getting oriented to do the job, and as they withdraw from the job. The dose received during these actions is called nonproductive. If several crew changes are required, the nonproductive dose can become very large. Thus it can be seen that the use of extra workers may actually increase the total occupational dose and the resulting collective risks.

The use of extra workers to comply with NRC dose limits is not the way to reduce the risk of radiation-induced cancer for the worker population. At best, the total risk remains the same, and it may even be increased. The only way to reduce the risk is to reduce the collective dose; that can be done only by reducing the radiation levels, the working times, or both.

17. Why doesn't the NRC impose collective dose limits?

Compliance with individual dose limits can be achieved simply by using extra workers. However, compliance with a collective dose limit (such as 100 person-rems per year for a licensee) would require reduction of radiation levels, working times, or both. But there are many problems associated with setting appropriate collective dose limits.

For example, we might consider applying a single collective dose limit to all licensees. The selection of such a collective dose limit would be almost impossible because of the wide variations in collective doses among licensees. A power reactor could reasonably be expected to have an average annual collective dose of several hundred person-rems. However, a small industrial radiography licensee could very well have a collective dose of only a few person-rems in a year.

Even choosing a collective dose limit for a group of similar licensees would be almost as difficult. Radiography licensees as a group had an average collective dose in 1977 of 9 person-rems. However, the smallest collective dose for a radiography licensee was less than 1 person-rem, and the largest was 401 person-rems.

Setting a reasonable collective dose limit for each individual licensee would also be very difficult. It would require a record of all past collective doses on which to base such limits. Setting an annual collective dose limit would then amount to an attempt to predict a reasonable collective dose for each future year. In order to do this, it would be necessary to be able to predict changes in each licensed activity that would increase or decrease the collective dose. In addition, annual collective doses vary significantly from year to year according to the kind and amount of maintenance required, which cannot generally be predicted in advance. Following all such changes and revising limits up and down would be very difficult if not impossible. However, these efforts would be necessary if a collective dose limit were to be reasonable and help minimize doses and risks.

18. How are radiation dose limits established?

The NRC establishes occupational radiation dose limits based on guidance to Federal agencies from the Environmental Protection Agency (EPA) and, in addition, considers NCRP and ICRP recommendations. Scientific reviews of research data on biological effects such as the BEIR report are also considered.

For example, recent EPA guidance recommended that the annual whole-body dose limit be established at 5 rems per year and indicated that exposure, year after year, to 5 rems would involve a risk to a worker comparable to the average risks incurred by workers in the higher risk jobs such as mining. In fact, few workers ever reach such a limit, much less year after year, and the risks associated with actual exposures are considered by the EPA to be comparable to the safer job categories. A 5-rem-per-year limit would allow occasional high dose jobs to be done without excessive risk.

19. What are the typical radiation doses received by workers?

The NRC requires that certain categories of licensees report data on annual worker doses and doses for all workers who leave employment with licensees. Data were received on the occupational doses in 1977 of approximately 100,000 workers in power reactors, industrial radiography, fuel processing and fabrication facilities, and manufacturing and distribution facilities. Of this total group, 85 percent received an annual dose of less than 1 rem; 95 percent received less than 2 rems; fewer than 1 percent exceeded 5 rems in 1 year. The average annual dose of those workers who were monitored and had measurable exposures was about 0.65 rem. A study completed by the EPA, using 1975 exposure data for 1,260,000 workers, indicated that the average annual dose for all workers who received a measurable dose was 0.34 rem.

Table 5 lists average occupational exposures for workers (persons who had measurable exposure above background levels) in various occupations, based on the 1975 data.

TABLE 5

U.S. Occupational Exposure Estimates[a]

Occupational Subgroup	Average Whole-Body Dose (millirems)	Collective Dose (person-rems)
Medicine	320	51,400
Industrial Radiography	580	5,700
Source Manufacturing	630	2,500
Power Reactors	760	21,400
Fuel Fabrication and Reprocessing	560	3,100
Uranium Enrichment	70	400
Nuclear Waste Disposal	920	100
Uranium Mills	380	760
Department of Energy Facilities	300	11,800
Department of Defense Facilities	180	10,100
Educational Institutions	206	1,500
Transportation	200	2,300

[a]Adapted from Cook and Nelson, *Occupational Exposures to Ionizing Radiation in the United States: A Comprehensive Summary for 1975*, Draft, Environmental Protection Agency.

20. What happens if a worker exceeds the quarterly exposure limit?

Radiation protection limits, such as 3 rems in 3 months, are not absolute limits below which it is safe and above which there is danger. Exceeding a limit does not imply that you have suffered an injury. A good comparison is with the highway speed limit, which is selected to limit accident risk and still allow you to get somewhere. If you drive at 75 mph, you increase your risk of an auto accident to levels that are not considered acceptable by the people who set speed limits, even though you may not actually have an accident. If a worker's radiation dose repeatedly exceeds 3 rems in a quarter, the risk of health effects could eventually increase to a level that is not considered acceptable to the NRC. Exceeding an NRC protection limit does not mean that any adverse health effects are going to occur. It does mean that a licensee's safety program has failed in some respect and that the NRC and the licensee should investigate to make sure the problems are corrected.

If an overexposure occurs, the regulations prohibit any additional occupational exposure to that person during the remainder of the calendar quarter in which the overexposure occurred. The licensee is required to file an overexposure report to the NRC and may possibly be subject to a fine, just as you are subject to a traffic fine for exceeding the speed limit. In both cases, the fines and, in some serious or repetitive cases, suspension of license are intended to encourage efforts to operate within the limits. The safest limits would be 0 mph and 0 rem per quarter. But then we wouldn't get anywhere.

21. Why do some facilities establish administrative limits that are below the NRC limits?

There are two reasons. First, the NRC regulations state that licensees should keep exposures to radiation ALARA. By requiring specific approval for worker doses in excess of set levels, more careful risk-benefit analysis can be made as each additional increment of dose is approved for a worker. Secondly, a facility administrative limit that is set lower than the quarterly NRC limit provides a safety margin designed to help the licensee avoid overexposures.

22. Several scientists have suggested that NRC limits are too high and should be lowered. What are the arguments for lowering the limits?

In general, those critical of present dose limits say that the individual risk is higher than is estimated by the BEIR Committee, the ICRP, and UNSCEAR. Based on studies of low-level exposures to large groups, some researchers have concluded that a given dose of radiation may be more likely to cause biological effects than previously thought. Some of these studies are listed in the bibliography (Mancuso, Archer) and the BEIR-80 report includes a section analyzing the findings of these and other studies. Scientific opinion differs on the validity of the research methods used and the methods of statistical analysis. The problem is that the expected additional incidence of radiation-caused effects such as cancer is difficult to detect in comparison with the much larger normal incidence. It cannot be shown without question that these effects were more frequent in the exposed study group than in the unexposed group used for comparison, or that the observed effects were caused by radiation. The BEIR committee concluded that claims of higher risk had "no substance."

The NRC staff continually reviews the results of research on radiation risks. With respect to large-scale studies of radiation-induced health effects in human populations exposed to low-level ionizing radiation, the NRC and EPA have recently concluded that there is no one population group available for which such a study could be expected to provide a more meaningful estimate of the low-level radiation risk. This is due, in large part, to the observed and estimated low incidence of radiation health effects from low doses. However, the results of ongoing studies, such as that on nuclear shipyard workers, will be carefully reviewed and the development of a radiation-worker registry is being considered as a possible data base for future studies.

23. What are the reasons for not lowering the NRC dose limits?

Assuming that the 5-rem-per-year limit is adopted, there are three reasons:

a. Health risks are already low.

The estimated health risks associated with current average occupational radiation doses (e.g., 0.5 rem/yr for 50 years) are comparable to or less than risk levels in other occupational areas considered to be among the safest. If a person were exposed to the maximum of 5 rems per year for 50 years, which virtually never occurs, he or she might incur a risk comparable to the average risks in mining and heavy construction. An occasional 5-rem annual dose might be necessary to allow some jobs to be done without a significant increase in the collective dose. If the dose limits were lowered significantly, the number of people required to complete many jobs would increase. The collective dose would then increase since more individuals would be receiving nonproductive exposure while entering and leaving the work area and preparing for the job. The total number of health effects might go up as the collective dose increased.

b. The current regulations are considered sound.

The regulatory standards for dose limits are based on the recommendations of the Federal Radiation Council. At the time these standards were developed, about 1960, it was considered unlikely that exposure to these levels during a working lifetime would result in clinical evidence of injury or disease different from that occurring in the unexposed population. The scientific data base for the standards consisted primarily of human experience (x-ray exposures to medical practitioners and patients, ingestion of radium by watch dial painters, early effects observed in Japanese atomic bomb survivors, radon exposures of uranium miners, occupational radiation accidents) involving very large doses delivered at high dose rates. The data base also included the results of a large number of animal experiments involving high doses and dose rates. The animal experiments were particularly useful in the evaluation of genetic effects. The observed effects were related to low-level radiation according to the linear model explained in Question 7. Based on this approach, the regulations in 10 CFR Part 20, "Standards for Protection Against Radiation," also state that licensees should maintain all radiation exposures, and releases of radioactive materials in effluents, as low as is reasonably achievable. More recent scientific reviews of the large body of experimental data, such as the BEIR-80 and the recent EPA guidance, continue to support the view that use of a 5-rem-per-year limit is acceptable in practice. Experience has shown that, under this limit, the average dose to workers is near 0.5 rem/yr with very few workers consistently approaching the limit.

c. There is little to gain.

Reducing the dose limits, for example, to 0.5 rem/yr has been analyzed by the NRC staff. An estimated 2.6 million person-rems could be saved from 1980 through the year 2000 by nuclear power plant licensees if compliance with the new limit were achieved by lowering the radiation levels, working times, or both, rather than by using extra workers. It is estimated that something like \$23 billion would be spent toward this purpose. Spending \$23 billion to save 2.6 million person-rems would amount to spending \$30 to \$90 million to prevent each potential radiation-induced premature cancer death. Society considers this cost unacceptably high for individual protection.

24. Are there any areas of concern about radiation risks that might result in changing the NRC dose limits?

Yes. Three areas of concern to the NRC staff are specifically identified below:

a. An independent study by Rossi and Mays and other biological research have indicated that a given dose of neutron radiation may be more likely to cause biological effects than was previously thought. Other recent studies cast doubt on the issue. The NCRP is currently studying the data related to the neutron radiation question and is expected to make recommendations as to whether neutron dose limits should be changed. Although the scientific community has not yet come to agreement on this question, workers should be advised of the possibility of higher risk when entering areas where exposure to neutrons will occur.

b. It has been known for some time that rapidly growing living tissue is more sensitive to injury from radiation than tissue in which the cells are not reproducing rapidly. Thus the embryo or fetus is more sensitive to radiation injury than an adult. The NCRP recommended in Report No. 39 that special precautions be taken when an occupationally exposed woman could be pregnant in order to protect the embryo or fetus. In 1975, the NRC issued Regulatory Guide 8.13, "Instruction Concerning Prenatal Radiation Exposure," in which it is recommended that licensees instruct all workers concerning this special risk. The guide recommends that all workers be advised that the NCRP recommended that the maximum permissible dose to the embryo or fetus from occupational exposure of the mother should not exceed 0.5 rem for the full 9-month pregnancy period. In addition, the guide suggests options available to the female employee who chooses not to expose her embryo or fetus to this additional risk.

The United States Department of Health and Human Services is similarly concerned about prenatal exposure from medical x-rays. In 1979 they published proposed guidelines for physicians concerning abdominal x-rays for possibly pregnant women. The guidelines in effect encourage the x-ray staff to make efforts to determine whether a female patient is pregnant and to defer x-rays if possible until after the child is born.

c. Also of special interest is the indication that female workers are subject to more risk of cancer incidence than male workers. In terms of all types of cancer except leukemia, the BEIR-80 analysis indicates that female workers have a risk of developing radiation-induced cancer that is approximately one and one-half times that for males. This increased risk is primarily due to the incidence of breast and thyroid cancer in women. These types of cancer, however, have a high cure rate. Thus the difference between men and women in cancer mortality is not great. Incidence of radiation-induced leukemia is about the same for both sexes. Female workers should be aware of this difference in the risks of radiation-induced cancer in deciding whether or not to seek work involving exposure to radiation.

25. *How much radiation does the average person who does not work in the nuclear industry receive?*

We are all exposed from the moment of conception to ionizing radiation from several sources. Our environment, and even the human body, contains naturally occurring radioactive materials that contribute some of the background radiation we receive. Cosmic radiation originating in space and in the sun contributes additional exposure. The use of x-rays and radioactive materials in medicine and dentistry adds considerably to our population exposure.

Table 6 shows estimated average individual exposure in millirems from natural background and other sources.

TABLE 6

U.S. General Population Exposure Estimates (1978)[a]

Source	Average Individual Dose (mrem/yr)
Natural background (average in U.S.)	100
Release of radioactive material in natural gas, mining, milling, etc.	5
Medical (whole-body equivalent)	90
Nuclear weapons (primarily fallout)	5-8
Nuclear energy	0.28
Consumer products	0.03
Total	∿200 mrem/yr

[a]Adapted from a report by the Interagency Task Force on the Health Effects of Ionizing Radiation published by the Department of Health, Education, and Welfare.

Thus, the average individual in the general population receives about 0.2 rem of radiation exposure each year from sources that are a part of our natural and man-made environment. By the age of 20 years, an individual has accumulated about 4 rems. The most likely target for reduction of population exposure is medical uses.

26. *Why aren't medical exposures considered as part of a worker's allowed dose?*

Equal doses of medical and occupational radiation have equal risks.[7] Medical exposure to radiation should be justified for reasons quite different, however, from those applicable to occupational exposure. A physician prescribing an x-ray should be convinced that the benefit to the patient of the resulting medical information justifies the risk associated with the radiation. Each worker must decide on the acceptance of occupational radiation risk just as each worker must decide on the acceptability of any other occupational hazard.

For another point of view, consider a worker who receives a dose of 2 rems from a series of x-rays or a radioactive medicine in connection with an injury or illness. This dose and the implied risk should be justified on medical grounds. If the worker had also received a dose of 2 rems on the job, the combined dose of 4 rems would not incapacitate the worker. A dose of 4 rems is not especially dangerous and is not large compared to the cumulative lifetime dose. Restricting the worker from additional job exposure during the remainder of the quarter would have no effect one way or the other on the risk from the 2 rems already received from medical exposure. If the individual worker accepts the risks associated with the x-rays on the basis of the medical benefits and the risks associated with job-related exposure on the basis of employment benefits, it would be unfair to restrict the individual from employment in radiation areas for the remainder of the quarter.

Some therapeutic medical doses such as those received from cobalt-60 treatment can range as high as 6000 rems to a small part of the body, spread over a period of several weeks or months.

27. *What is meant by internal exposure?*

The total radiation dose to the worker is the external dose (measured by the film badge and reported as "whole-body dose") plus the dose from internal emitters. The monitoring of the additional internal dose is difficult. Because there is the possibility of internal doses occurring, a good air-monitoring program should be established when warranted.

The uptake of radioactive materials by workers is generally due to breathing contaminated air. Radioactive materials may be present as fine dust or gases in the workplace atmosphere. The surfaces of equipment and workbenches

[7]It is likely that a significant portion of reported medical x-ray exposure is to parts of the body only. An exposure of 100 mrem to the whole body is more significant than a 100-mrem chest x-ray.

may be contaminated. Radioactive materials may enter the body by being breathed in, taken in with food or drink, or being absorbed through the skin, particularly if the skin is broken.

After entering the body, the radioactive material will migrate to particular organs or particular parts of the body depending on the biochemistry of the material. For example, uranium will tend to deposit in the bones where it will remain for a long time. It is slowly eliminated from the body, mostly by way of the kidneys. Radium will also tend to deposit in the bones. Radioactive iodine will seek out the thyroid glands (located in the neck) and deposit there.

The dose from these internal emitters cannot be measured either by the film badge or by other ordinary dosimeters carried by the worker. This means that the internal radiation dose must be separately monitored using other detection methods.

Internal exposure can be estimated by measuring the radiation emitted from the body or by measuring the radioactive materials contained in biological samples such as urine or feces. Dose estimates can also be made if one knows how much radioactive material is in the air and the length of time during which the air was breathed.

28. *How are the limits for internal exposure set?*

Standards have been established for the maximum permissible amount of each radionuclide that may be accumulated in the critical organs[8] of the worker's body.

Calculations are made to determine the quantity of radioactive material that has been taken into the body and the total dose that would result. Then, based on limits established for particular body organs similar to 1¼ rems in a calendar quarter for whole-body exposure, the regulations specify maximum permissible concentrations of radioactive material in the air to which a worker can be exposed for 40 hours per week over 13 weeks or 1 calendar quarter. The regulations also require that efforts be made to keep internal exposure ALARA.

Internal exposure is controlled by limiting the release of radioactive material into the air and by carefully monitoring the work area for airborne radioactivity and surface contamination. Protective clothing and respiratory (breathing) protection should be used whenever the possibility of contact with loose radioactive material cannot be prevented.

29. *Is the dose a person received from internal exposure added to that received from external exposure?*

Exposure to radiation that results from radioactive materials taken into the body is measured, recorded, and reported to the worker separately from external dose. The internal dose to the whole body or to specific organs does not at this time count against the 3-rem-per-calendar-quarter limit. ICRP recommends that the internal and external doses should be appropriately added. This recommendation is currently under study by the staffs of the NRC, the EPA, and the Occupational Safety and Health Administration (OSHA).

[8]Critical organ refers to those parts of the body vulnerable to radiation damage such as bone, lungs, thyroid, and other systems where certain radioactive materials will concentrate if taken into the body.

30. *How is a worker's external radiation dose determined?*

A worker may wear three types of radiation-measuring devices. A self-reading pocket dosimeter records the exposure to incident radiation and can be read out immediately upon finishing a job involving external exposure to radiation. A film badge or TLD badge records radiation dose, either by the amount of darkening of the film or by storing energy in the TLD crystal. Both these devices require processing to determine the dose but are considered more reliable than the pocket dosimeter. A worker's official report of dose received is normally based on film or TLD badge readings, which provide a cumulative total and are more accurate.

31. *What are my options if I decide not to accept the risks associated with occupational radiation exposure?*

If the risks from exposure to radiation that may be expected to occur during your work are unacceptable to you, you could request a transfer to a job that does not involve exposure to radiation. However, the risks associated with exposure to radiation that workers, on the average, actually receive are considered acceptable, compared to other occupational risks, by virtually all the scientific groups that have studied them. Your employer is probably not obligated to guarantee you a transfer if you decide not to accept an assignment requiring exposure to radiation.

You also have the option of seeking other employment in a nonradiation occupation. However, the studies that have compared occupational risks in the nuclear industry to those in other job areas indicate that nuclear work is relatively safe. Thus, you will not necessarily find significantly lower risks in another job.

A third option would be to practice the most effective work procedures so as to keep your exposure ALARA. Be aware that reducing time of exposure, maintaining distance from radiation sources, and using shielding can all lower your exposure. Plan radiation jobs carefully to increase efficiency while in the radiation area. Learn the most effective methods of using protective clothing to avoid contamination. Discuss your job with the radiation protection personnel who can suggest additional ways to reduce your exposure.

32. *Where can I get additional information on radiation risk?*

The following list suggests sources of useful information on radiation risk:

a. Your Employer

The radiation protection or health physics office in the facility where you are employed.

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PROCEDURES FOR ORDERING AND ACCEPTING DELIVERY OF RADIOACTIVE MATERIAL

1. The Nuclear Medicine Technologist at each imaging center will place all orders for radioactive materials and will ensure that the requested materials and quantities are authorized by the license and that possession limits are not exceeded.

2. A system for ordering and receiving radioactive materials will be established and maintained. The system will consist minimally of the following:

   a. Ordering of routinely used materials

      (1) Written records that identify the isotope, compound, activity levels, and supplier, etc. will be used.

      (2) The written records will be referenced when opening or storing radioactive shipment.

   b. Ordering of specially used materials

      (1) A written request* will be obtained from the physician who will perform the procedure.

      (2) Persons ordering the materials will reference the physician's written request when placing the order. The physician's request will indicate isotope, compound, activity level, etc.

      (3) The physician's written request will be referenced when receiving, opening, or storing the radioactive material.

   c. It is essential that written records* be maintained for all ordering and receipt procedures.

3. During normal working hours, carriers will be instructed to deliver radioactive packages directly to the Nuclear Medicine area.

4. During off-duty hours, we will not accept delivery of radioactive packages.

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* In the case of special orders, the physician's written request and appropriate shipping/receipt records will be referenced and the dose assayed prior to its administration.

RADIOACTIVE SHIPMENT HANDLING

AND INSPECTION FORM

Date Surveyed: ______________________________ Lot No. __________________________

VISUAL

Exterior Package Condition

☐ OK ☐ Damaged ______________________________

(If damaged perform wipe test)

EXTERNAL RADIATION SURVEY

(a) At 3 feet ____________________ mR/hr (Limit = 10 mR/hr

(b) Surface ____________________ mRhr (Limit = 200 mR/hr

Interior Package Condition

☐ OK ☐ Damaged ______________________________

(If damaged perform wipe test)

INTERNAL RADIATION SURVEY

Inside of package with source removed ____________________ mR hr

CONTENT

Radionuclide and form

Packing Slip ________________

Vial Label ________________

WIPE TEST (IF INDICATED)

Exterior ________________ CPM

Interior ________________ CPM

WIPE TEST PROCEDURE

Surveys are performed with a low level G M survey meter with shield open. Wipe tests are performed with Alco wipes, or similar absorbent and counted at surface of a rubber or plastic protected G M probe on the most sensitive scale range.

Surveyed by ______________________________

Nuclear and Radiologic Imaging Physicians, P.C.

NRC-313M

Item 17

AREA SURVEY PROCEDURES (WIPES)

We wish to amend Appendix I for our wipe test procedures to permit assay of wipe samples with our GM survey meter as follows:

a. Instrument sensitivity on most sensitive scale is 0-0.2mR/hr.
b. Efficiency for common medical nuclides is approximately 100% for beta and 1% for gamma rays.
c. Wipe test analysis will be conducted in a low background area.
d. The beta shield will be removed during wipe test analysis.
e. The GM probe will be covered with a plastic glove and each wipe will be placed directly over the open "window" of the detector.
f. The RC time constant will be slow and used during each wipe analysis and will be 15 seconds in duration.
g. Action level for decontamination will be any response above background.

APPENDIX J

WASTE DISPOSAL

Note: In view of the recent problems with shallow-land burial sites used by commercial waste disposal firms, NRC is encouraging its licensees to reduce the volume of wastes sent to these facilities. Important steps in volume reduction are to segregate radioactive from nonradioactive waste, to hold short-lived radioactive waste for decay in storage, and to release certain materials in the sanitary sewer in accordance with §20.303 of 10 CFR Part 20.

1. Liquid waste will be disposed of (check as appropriate)

_______ In the sanitary sewer system in accordance with §20.303 of 10 CFR Part 20.

_______ By commercial waste disposal service (see also Item 4 below).

_______ Other (specify): _______________________

2. Mo-99/Tc-99m generators will be (check as appropriate)

_______ Returned to the manufacturer for disposal.

_______ Held for decay* until radiation levels, as measured in a low background area with a low-level survey meter and with all shielding removed, have reached background levels. All radiation labels will be removed or obliterated, and the generators will be disposed of as normal trash.**

_______ Disposed of by commercial waste disposal service (see also Item 4 below).

_______ Other (specify): _______________________

3. Other solid waste will be (check as appropriate)

___X___ Held for decay* until radiation levels, as measured in a low background area with a low-level survey meter and with all shielding removed, have reached background levels. All radiation labels will be removed or obliterated, and the waste will be disposed of in normal trash.

_______ Disposed of by commercial waste disposal service (see also Item 4 below).

_______ Other (specify): _______________________

4. The commercial waste disposal service used will be

ADCO Services
(Name) (City, State)

NRC/Agreement State License No. 12-11286-01

*Be sure that waste storage areas were described in Item 11 and that they are surveyed periodically (Item 17).

**These generators may contain long-lived radioisotopic contaminants. Therefore, the generator columns will be segregated so that they may be monitored separately to ensure decay to background levels prior to disposal.

Additionally, NO liquid waste will be generated or disposed of in any imaging center.

APPENDIX O

MODEL PROGRAM FOR MAINTAINING OCCUPATIONAL RADIATION EXPOSURES AT MEDICAL INSTITUTIONS ALARA

Nuclear and Radiologic Imaging Physicians, P.C.

(Licensee's Name)

March 11, 1985

(Date)

1. Management Commitment

a. We, the management of this (medical facility, hospital, etc.), are committed to the program described in this paper for keeping exposures (individual and collective) as low as is reasonably achievable (ALARA). In accord with this commitment, we hereby describe an administrative organization for radiation safety and will develop the necessary written policy, procedures, and instructions to foster the ALARA concept within our institution. The organization will include a Radiation Safety Committee (RSC)[1] and Radiation Safety Officer (RSO).

b. We will perform a formal annual review of the radiation safety program, including ALARA considerations. This shall include reviews of operating procedures and past exposure records, inspections, etc., and consultations with the radiation protection staff or outside consultants.

c. Modification to operating and maintenance procedures and to equipment and facilities will be made where they will reduce exposures unless the cost, in our judgment, is considered to be unjustified. We will be able to demonstrate, if necessary, that improvements have been sought, that modifications have been considered, and that they have been implemented where reasonable. Where modifications have been recommended but not implemented, we will be prepared to describe the reasons for not implementing them.

d. In addition to maintaining doses to individuals as far below the limits as is reasonably achievable, the sum of the doses received by all exposed individuals will also be maintained at the lowest practicable level. It would not be desirable, for example, to hold the highest doses to individuals to some fraction of the applicable limit if this involved exposing additional people and significantly increasing the sum of radiation doses received by all involved individuals.

[1]Private practice physician licenses do not include an RSC.

2. Radiation Safety Committee (RSC)[2]

a. Review of Proposed Users and Uses

(1) The RSC will thoroughly review the qualifications of each applicant with respect to the types and quantities of materials and uses for which he has applied to ensure that the applicant will be able to take appropriate measures to maintain exposure ALARA.

(2) When considering a new use of byproduct material, the RSC will review the efforts of the applicant to maintain exposure ALARA. The user should have systematized procedures to ensure ALARA and shall have incorporated the use of special equipment such as syringe shields, rubber gloves, etc., in his proposed use.

(3) The RSC will ensure that the user justifies his procedures and that dose will be ALARA (individual and collective).

b. Delegation of Authority

(The judicious delegation of RSC authority is essential to the enforcement of an ALARA program.)

(1) The RSC will delegate authority to the RSO for enforcement of the ALARA concept.

(2) The RSC will support the RSO in those instances where it is necessary for the RSO to assert his/her authority. Where the RSO has been overruled, the Committee will record the basis for its action in the minutes of the Committee's quarterly meeting.

[2]The RSO on private practice physician licenses will assume the responsibilities of the RSC under Section 2.

c. Review of ALARA Program

(1) The RSC will encourage all users to review current procedures and develop new procedures as appropriate to implement the ALARA concept.

(2) The RSC will perform a quarterly review of occupational radiation exposure with particular attention to instances where Investigational Levels in Table 0-1 below are exceeded. The principal purpose of this review is to assess trends in occupational exposure as an index of the ALARA program quality and to decide if action is warranted when Investigational Levels are exceeded (see Section 6).[3]

(3) The RSC will evaluate our institution's overall efforts for maintaining exposures ALARA on an annual basis. This review will include the efforts of the RSO, authorized users, and workers as well as those of management.

3. **Radiation Safety Officer (RSO)**

a. Annual and Quarterly Review

(1) Annual review of the radiation safety program. The RSO will perform an annual review of the radiation safety program for adherence to ALARA concepts. Reviews of specific procedures may be conducted on a more frequent basis.

(2) Quarterly review of occupational exposures. The RSO will review at least quarterly the external radiation exposures of authorized users and workers to determine that their exposures are ALARA in accordance with the provisions of Section 6 of this program.

(3) Quarterly review of records of radiation level surveys. The RSO will review radiation levels in unrestricted and restricted areas to determine that they were at ALARA levels during the previous quarter.

b. Education Responsibilities for ALARA Program

(1) The RSO will schedule briefings and educational sessions to inform workers of ALARA program efforts.

(2) The RSO will ensure that authorized users, workers, and ancillary personnel who may be exposed to radiation will be instructed in the ALARA philosophy and informed that management, the RSC, and the RSO are committed to implementing the ALARA concept.

c. Cooperative Efforts for Development of ALARA Procedures

Radiation workers will be given opportunities to participate in formulation of the procedures that they will be required to follow.

(1) The RSO will be in close contact with all users and workers in order to develop ALARA procedures for working with radioactive materials.

(2) The RSO will establish procedures for receiving and evaluating the suggestions of individual workers for improving health physics practices and will encourage the use of those procedures.

d. Reviewing Instances of Deviation from Good ALARA Practices

The RSO will investigate all known instances of deviation from good ALARA practices and, if possible, will determine the causes. When the cause is known, the RSO will require changes in the program to maintain exposures ALARA.

4. **Authorized Users**

a. New Procedures Involving Potential Radiation Exposures

(1) The authorized user will consult with, and receive the approval of, the RSO and/or RSC during the planning stage before using radioactive materials for a new procedure.

(2) The authorized user will evaluate all procedures before using radioactive materials to ensure that exposures will be kept ALARA. This may be enhanced through the application of trial runs.

b. Responsibility of Authorized User to Persons Under His/Her Supervision

(1) The authorized user will explain the ALARA concept and his/her commitment to maintain exposures ALARA to all persons under his/her supervision.

(2) The authorized user will ensure that persons under his/her supervision who are

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[3]The NRC has emphasized that the Investigational Levels in this program are not new dose limits but, as noted in ICRP Report 26, "Recommendations of the International Commission on Radiological Protection," serve as check points above which the results are considered sufficiently important to justify further investigations.

subject to occupational radiation exposure are trained and educated in good health physics practices and in maintaining exposures ALARA.

5. **Persons Who Receive Occupational Radiation Exposure**

a. The worker will be instructed in the ALARA concept and its relationship to working procedures and work conditions.

b. The worker will know what recourses are available if he/she feels that ALARA is not being promoted on the job.

6. **Establishment of Investigational Levels In Order to Monitor Individual Occupational External Radiation Exposures**

This institution (or private practice) hereby establishes Investigational Levels for occupational external radiation exposure which, when exceeded, will initiate review or investigation by the RSC and/or the RSO. The Investigational Levels that we have adopted are listed in Table O-1 below. These levels apply to the exposure of individual workers.

Table 0-1

	Investigational Levels (mrems per calendar quarter)	
	Level I	*Level II*
1. Whole body; head and trunk; active blood-forming organs; lens of eyes; or gonads	125	375
2. Hands and forearms; feet and ankles	1875	5625
3. Skin of whole body*	750	2250

*Not normally applicable to nuclear medicine operations except those using significant quantities of beta-emitting isotopes.

The Radiation Safety Officer will review and record on Form NRC-5, "Current Occupational External Radiation Exposures," or an equivalent form (e.g., dosimeter processor's report), results of personnel monitoring not less than once in any calendar quarter as required by §20.401 of 10 CFR Part 20. The following actions will be taken at the Investigational Levels as stated in Table 0-1:

a. Quarterly exposure of individuals to less than Investigational Level I.

Except when deemed appropriate by the RSO, no further action will be taken in those cases where an individual's exposure is less than Table 0-1 values for the Investigational Level I.

b. Personnel exposures equal to or greater than Investigational Level I, but less than Investigational Level II.

The RSO will review the exposure of each individual whose quarterly exposures equal or exceed Investigational Level I and will report the results of the reviews at the first RSC meeting following the quarter when the exposure was recorded. If the exposure does not equal or exceed Investigational Level II, no action related specifically to the exposure is required unless deemed appropriate by the Committee. The Committee will, however, consider each such exposure in comparison with those of others performing similar tasks as an index of ALARA program quality and will record the review in the Committee minutes.

c. Exposure equal to or greater than Investigational Level II.

The RSO will investigate in a timely manner the cause(s) of all personnel exposures equaling or exceeding Investigational Level II and, if warranted, will take action. A report of the investigation, actions taken, if any, and a copy of the individual's Form NRC-5 or its equivalent will be presented to the RSC at the first RSC meeting following completion of the investigation. The details of these reports will be recorded in the RSC minutes. Committee minutes will be sent to the management of this institution for review. The minutes, containing details of the investigation, will be made available to NRC inspectors for review at the time of the next inspection.

d. Reestablishment of an individual occupational worker's Investigational Level II to a level above that listed in Table 0-1.

In cases where a worker's or a group of workers' exposures need to exceed Investigational Level II, a new, higher Investigational Level II may be established on the basis that it is consistent with good ALARA practices for that individual or group. Justification for a new Investigational Level II will be documented.

The RSC will review the justification for, and will approve, all revisions of Investigational Level II. In such cases, when the exposure equals or exceeds

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the newly established Investigational Level II, those actions listed in paragraph 6.c above will be followed.

7. **Signature of Certifying Official**[4]

I hereby certify that this institution (or private practice) has implemented the ALARA Program set forth above.

Subhash C Khullar.

Signature

Subhash C. Khullar, M.D.

Name (print or type)

President.

Title

Institution (or Private Practice) Name and Address

Nuclear & Radiologic Imaging Physicians, P.C.
2151 Livernois, Suite 201
Troy, Michigan 48083

[4]The person who is authorized to make commitments for the dministration of the institution (e.g., hospital administrator) or, n the case of a private practice, the licensed physician.

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