



FALMOUTH HOSPITAL

TER HEUN DRIVE / FALMOUTH, MASSACHUSETTS 02540 / TELEPHONE (617) 548-5300

Dr. John Glenn
U.S. Nuclear Regulatory Commission
Region I
631 Park Avenue
King of Prussia PA 019406

RECEIVED

'87 NOV 17 A9:37

Dear Dr. Glenn,

This letter is to request the addition of William Myron Hike, M.D. to NRC license # 20-16389-01 issued to the Falmouth Hospital, Falmouth Massachusetts. Attached are his credentials to support this request.

Sincerely,

Roy Hitchings
President

Log	Nov. 7
Remitter	
Check No.	0488
Amount	\$120
Fec. Code	2C
Type of Fee	AMD
Date Check Rec'd.	11/17/87
Date Completed	11/17/87
By:	A. Kimberley

"OFFICIAL RECORD COPY"

ML10

8902150251 871214
REG1 LIC30
20-16389-01 PNU

03 NOV 1987
108017

12/1/86 - 1/31/87
2/1 - 2/28/87

NRC FORM 313M SUPPLEMENT B
(9-81)

U. S. NUCLEAR REGULATORY COMMISSION

PRECEPTOR STATEMENT

Supplement B must be completed by the applicant physician's preceptor. If more than one preceptor is necessary to document experience, obtain a separate statement from each.

1. APPLICANT PHYSICIAN'S NAME AND ADDRESS

FULL NAME

William Myron Hike

STREET ADDRESS

40 Seminary Rd.

CITY

Simsbury,

STATE

CT

ZIP CODE

06070

KEY TO COLUMN C

PERSONAL PARTICIPATION SHOULD CONSIST OF:

- 1-Supervised examination of patients to determine the suitability for radioisotope diagnosis and/or treatment and recommendation for prescribed dosage.
- 2-Collaboration in dose calibration and actual administration of dose to the patient including calculation of the radiation dose, related measurements and plotting of data.
- 3-Adequate period of training to enable physician to manage radioactive patients and follow patients through diagnosis and/or course of treatment.

2. CLINICAL TRAINING AND EXPERIENCE OF ABOVE NAMED PHYSICIAN

ISOTOPE A	CONDITIONS DIAGNOSED OR TREATED B	NUMBER OF CASES INVOLVING PERSONAL PARTICIPATION C	COMMENTS (Additional information or comments may be submitted in duplicate on separate sheets.) D
I-131 or I-125	DIAGNOSIS OF THYROID FUNCTION	25	
	DETERMINATION OF BLOOD AND BLOOD PLASMA VOLUME	—	
	LIVER FUNCTION STUDIES	—	
	FAT ABSORPTION STUDIES	—	
	KIDNEY FUNCTION STUDIES	—	
	IN VITRO STUDIES	—	
OTHER			
I-125	DETECTION OF THROMBOSIS	—	
I-131	THYROID IMAGING	—	
P-32	EYE TUMOR LOCALIZATION	—	
Se-75	PANCREAS IMAGING	—	
Yb-169	CISTERNOGRAPHY	1	
Xe-133	BLOOD FLOW STUDIES AND PULMONARY FUNCTION STUDIES	112	
OTHER	201 Tl Heart	47	
Tc-99m	BRAIN IMAGING	5	
	CARDIAC IMAGING	196	
	THYROID IMAGING	64	
	SALIVARY GLAND IMAGING	1	
	BLOOD POOL IMAGING	1	
	PLACENTA LOCALIZATION	—	
	LIVER AND SPLEEN IMAGING	95	
	LUNG IMAGING	122	
	BONE IMAGING	353	
OTHER	Tc-Renal	75	

108017

03 NOV 1987

PRECEPTOR STATEMENT (Continued)

2. CLINICAL TRAINING AND EXPERIENCE OF ABOVE NAMED PHYSICIAN (Continued)

ISOTOPE	CONDITIONS DIAGNOSED OR TREATED	NUMBER OF CASES INVOLVING PERSONAL PARTICIPATION	COMMENTS (Additional information or comments may be submitted in duplicate on separate sheets.)
A	B	C	D
P-32 (Soluble)	TREATMENT OF POLYCYTHEMIA VERA, LEUKEMIA, AND BONE METASTASES	1	No therapy
P-32 (Colloidal)	INTRACAVITARY TREATMENT	1	
I-131	TREATMENT OF THYROID CARCINOMA	1	
	TREATMENT OF HYPERTHYROIDISM	1	
Au-198	INTRACAVITARY TREATMENT	1	
Co-60 or Cs-137	INTERSTITIAL TREATMENT	0	
	INTRACAVITARY TREATMENT	1	
I-125 or Ir-192	INTERSTITIAL TREATMENT	1	
	TELETHERAPY TREATMENT	1	
Sr-90	TREATMENT OF EYE DISEASE	1	
	RADIOPHARMACEUTICAL PREPARATION	1	
Mo-99/ Tc-99m	GENERATOR	5	
Sn-113/ In-113m	GENERATOR	1	
Tc-99m	REAGENT KITS	5	
Other			

3. DATES AND TOTAL NUMBER OF HOURS RECEIVED IN CLINICAL RADIOISOTOPE TRAINING

12/1/85 - 1/31/86; 2/1/87 - 2/28/87.

480 hours

4. THE TRAINING AND EXPERIENCE INDICATED ABOVE WAS OBTAINED UNDER THE SUPERVISION OF:

a. NAME OF SUPERVISOR

Fred Ziter, M.D.

b. NAME OF INSTITUTION

Hartford Hospital

c. MAILING ADDRESS

80 Seymour Street

d. CITY

Hartford, Ct. 06115

5. MATERIALS LICENSE NUMBER(S)

06-00253-04

6. PRECEPTOR'S SIGNATURE

John J. Sziklas, MD

7. PRECEPTOR'S NAME (Please type or print)

JOHN J. SZIKLAS

8. DATE

4/14/87

TRAINING AND EXPERIENCE
AUTHORIZED USER OR RADIATION SAFETY OFFICER

1. NAME OF AUTHORIZED USER OR RADIATION SAFETY OFFICER William Myron Hike, M.D.		2. STATE OR TERRITORY IN WHICH LICENSED TO PRACTICE MEDICINE Massachusetts		
3. CERTIFICATION				
SPECIALTY BOARD A	CATEGORY B	MONTH AND YEAR CERTIFIED C		
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	Hartford Hospital (8/84-7/86)	140		
b. RADIATION PROTECTION	Hartford Hospital (8/84-7/86)	15		
c. MATHEMATICS PERTAINING TO THE USE AND MEASUREMENT OF RADIOACTIVITY	Hartford Hospital (8/84-7/86)	10		
d. RADIATION BIOLOGY	Hartford Hospital (8/84-7/86)	25		
e. RADIOPHARMACEUTICAL CHEMISTRY	Hartford Hospital (8/84-7/86)	10		
5. EXPERIENCE WITH RADIATION. (Actual use of Radioisotopes or Equivalent Experience)				
ISOTOPE	MAXIMUM AMOUNT	WHERE EXPERIENCE WAS GAINED	DURATION OF EXPERIENCE	TYPE OF USE
Tl-201	5 mCi	Hartford Hospital 80 Seymour Street Hartford, CT 06115	1 yr. and 3 months	Diagnostic
Tc-99m	25 mCi			
Ga-67	5 mCi			
Xe-133	12 mCi			
Yb-169	2 mCi			
I-125	1 mCi			

PRECEPTOR STATEMENT

Supplement B must be completed by the applicant physician's preceptor. If more than one preceptor is necessary to document experience, obtain a separate statement from each.

1. APPLICANT PHYSICIAN'S NAME AND ADDRESS

FULL NAME

WILLIAM MYRON HIKE, M.D.

STREET ADDRESS

FALMOUTH HOSPITAL
TER HUGH DRIVE

CITY

FALMOUTH

STATE

MA

ZIP CODE

02540

KEY TO COLUMN C

PERSONAL PARTICIPATION SHOULD CONSIST OF:

1-Supervised examination of patients to determine the suitability for radioisotope diagnosis and/or treatment and recommendation for prescribed dosage.

2-Collaboration in dose calibration and actual administration of dose to the patient including calculation of the radiation dose, related measurements and plotting of data.

3-Adequate period of training to enable physician to manage radioactive patients and follow patients through diagnosis and/or course of treatment.

2. CLINICAL TRAINING AND EXPERIENCE OF ABOVE NAMED PHYSICIAN

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	DETERMINATION OF BLOOD AND BLOOD PLASMA VOLUME		
	LIVER FUNCTION STUDIES		
	FAT ABSORPTION STUDIES		
	KIDNEY FUNCTION STUDIES		
	IN VITRO STUDIES		
OTHER			
I-125	DETECTION OF THROMBOSIS		
I-131 I-123	THYROID IMAGING	3	
P-32	EYE TUMOR LOCALIZATION		
Se-75	PANCREAS IMAGING		
Yb-169	CISTERNOGRAPHY		
Xe-133	BLOOD FLOW STUDIES AND PULMONARY FUNCTION STUDIES		
OTHER			
Tc-99m	BRAIN IMAGING		
	CARDIAC IMAGING		
	THYROID IMAGING		
	SALIVARY GLAND IMAGING		
	BLOOD POOL IMAGING	2	
	PLACENTA LOCALIZATION		
	LIVER AND SPLEEN IMAGING	8	
	LUNG IMAGING	8	
	BONE IMAGING	21	
OTHER	BILIARY	8	

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PRECEPTOR STATEMENT (Continued)

2. CLINICAL TRAINING AND EXPERIENCE OF ABOVE NAMED PHYSICIAN (Continued)

ISOTOPE A	CONDITIONS DIAGNOSED OR TREATED B	NUMBER OF CASES INVOLVING PERSONAL PARTICIPATION C	COMMENTS (Additional information or comments may be submitted in duplicate on separate sheets.) D
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Au-198	INTRACAVITARY TREATMENT		
Co-60 or Cs-137	INTERSTITIAL TREATMENT		
	INTRACAVITARY TREATMENT		
I-125 or Ir-192	INTERSTITIAL TREATMENT		
Co-60 or Cs-137	TELE THERAPY TREATMENT		
Sr-90	TREATMENT OF EYE DISEASE		
	RADIOPHARMACEUTICAL PREPARATION		
Mo-99/ Tc-99m	GENERATOR		
Sn-113/ In-113m	GENERATOR		
Tc-99m	REAGENT KITS		
Other			

3. DATES AND TOTAL NUMBER OF HOURS RECEIVED IN CLINICAL RADIOISOTOPE TRAINING

7/1/87 - 9/30/87

27 HOURS

4. THE TRAINING AND EXPERIENCE INDICATED ABOVE
WAS OBTAINED UNDER THE SUPERVISION OF:

a. NAME OF SUPERVISOR

JAMES J. CONDON, M.D.

b. NAME OF INSTITUTION

FALMOUTH HOSPITAL

c. MAILING ADDRESS

100 HAVEN DRIVE

d. CITY

FALMOUTH, MA. 02540

5. MATERIALS LICENSE NUMBER(S)

20-16389-01

6. PRECEPTOR'S SIGNATURE

✓

7. PRECEPTOR'S NAME (Please type or print)

JAMES J. CONDON

8. DATE

BETWEEN:

LICENSE FEE MANAGEMENT BRANCH, ARM
AND
REGIONAL LICENSING SECTIONS

(FOR LFMS USE)
INFORMATION FROM LMS

PROGRAM CODE: 02120
STATUS CODE: 0
FEE CATEGORY: 7C
EXP. DATE: 19910831
FEE COMMENTS: -----
.....

LICENSE FEE TRANSMITTAL

A. REGION I

1. APPLICATION ATTACHED

APPLICANT/LICENSEE: FALMOUTH HOSPITAL
RECEIVED DATE: 871103
DOCKET NO: 3010938
CONTROL NO.: 108017
LICENSE NO.: 20-16389-01
ACTION TYPE: AMENDMENT

2. FEE ATTACHED

AMOUNT: 120.00
CHECK NO.: 0458

3. COMMENTS

SIGNED
DATE

[Signature]
11/12/87

B. LICENSE FEE MANAGEMENT BRANCH (CHECK WHEN MILESTONE 03 IS ENTERED 1✓)

1. FEE CATEGORY AND AMOUNT: 7C \$120

2. CORRECT FEE PAID. APPLICATION MAY BE PROCESSED FOR:

AMENDMENT ✓
RENEWAL _____
LICENSE _____

3. OTHER _____

SIGNED
DATE

[Signature]
11/17/87