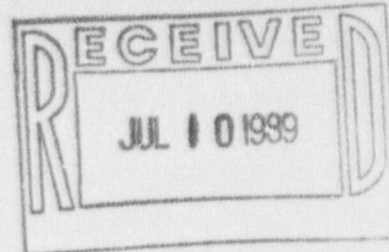


EDMOND
MEMORIAL
HOSPITAL



RESPONSE TO: A. BILL BEACH, DIRECTOR
US NRC

REGARDING: RESPONSE TO NOTICE OF
VIOLATION OF JUNE 5, 1989

20 JUNE 1989

A. Bill Veach
United States Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive, Suite 1000
Irving, TX 75061

Subject: Notice of Violation, 5 June, 1989 for NRC License
35-16494-01, Docket 30-11137/89-01

Dear Mr. Beach:

We wish to respond to the five (5) areas of violation as reported in your letter of 5 June 1989 by referencing our letters of May 4 and May 22, 1989 and the appendices accompanying those letters.

1. Dose Calibrator Constancy test procedure

As we stated in our letter of May 22, 1989, we have changed the method for the constancy test and are now using 137Cs. The reading for the 137Cs source is taken on several radionuclide settings and the recorded results are compared with decay corrected values for the expected results obtained from each of these settings. The expected results and the +/-5% range for each are recorded on each month's log sheet such that they are readily available for comparison.

We believe that this method meets the intention of the constancy test as outlined in Appendix D. Section 2.C(7).

2. Failure to test the dose calibrator for linearity of response at least quarterly.

As we stated in our letter of May 4, 1989, the results of the linearity test and other recurring tests will be performed near the time of the Radiation Safety Committee meeting. The reports will be submitted to the Hospital Radiation Safety Committee each quarter and the results will be recorded in the minutes of the meeting.

One South Bryant
Edmond, Oklahoma 73034
Telephone (405) 341-6100

8907190070 890620
REG4 LIC30
35-16494-01 PDC

An Affiliate of
HEALTHTRUST
INC. The Hospital Company

89-256
xc

IE-07
110

A report of dose calibrator linearity will be presented at the next meeting of the Radiation Safety Committee.

3. Failure to maintain disposal records of by-product material.

As we stated in our letter of May 4, 1989, we have developed new forms to record the disposal of radioactive waste. These forms more adequately reflect the procedures which we have been following to manage radioactive waste. With these forms a log will be maintained of all radioactive material receipt and disposal. The technologist using the material will indicate at the time of use the following:

- A - material administered to patient
- D - material decayed in laboratory
(flood doses, standards, etc.)
- R - material returned to nuclear pharmacy
for credit, unused

All syringes, needles and vials received from the nuclear pharmacy are returned to the nuclear pharmacy in their original containers.

Another of the forms in our letter of May 4, 1989, records the disposition of all other radioactive waste. This waste includes additional needles and syringes, gloves, swabs, radioaerosol kits and other miscellaneous materials.

These forms are in use at this time and we believe that the procedure is working correctly.

4. Failure of the Medical Isotopes Committee to meet on a quarterly frequency.

As we stated in our letter of May 4, 1989, the responsibility for scheduling the Radiation Safety Committee has been placed in the administrator's office. The meetings will be held quarterly in January, April, July and October. The Radiation Safety Officer, Hospital Administrator (or designee), Director of Radiology Services, Representative from the Medical Staff, Nuclear Medicine Technologist, Nursing Representative and consulting physicist will regularly attend.

The minutes of the meeting will be provided to the members. The consultant recommendations and committee actions will be reviewed at the subsequent meeting to be certain that recommendations and actions are being followed.

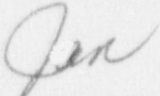
Our next meeting is actually scheduled for June, 1989.

5. Failure of the Medical Isotopes Committee to review quarterly the occupational radiation dose records of all personnel working with by-product material on a quarterly frequency.

Our plan to monitor radiation exposure of all affected personnel is proceeding as we outlined in our letter of May 4, 1989. As we stated in that letter, it is the responsibility of the Radiation Safety Office to review the occupational exposure records of employees on a monthly basis as they are received from the vendor and to take any action which may be required. Our consulting physicist will review the exposure records on June 30, 1989, and report to the Radiation Safety Committee at that time.

Mr. Beach, we sincerely hope that this letter and our plans to meet these important requirements of the NRC meet with your approval. Should you need additional information, we shall be pleased to respond.

Sincerely,



Jan Carrell
Acting Administrator

cc. Vernon J. Ficken, PhD.
Larry K. Killebrew, M.D.
Cleo Hunt