NRC FORM 592M
(10-2020)

U.S. NUCLEAR REGULATORY COMMISSION

Materials Inspection Record

1. Licensee Name:	2. Docket Number(s):	3. License Number(s)
Medical Clinic of Northville	030-35012	21-32174-01

4. Report Number(s):	5. Date(s) of Inspection:
2022-001	March 30, 2022; exit April 4, 2022

6. Inspector(s):	7. Program Code(s):	8. Priority:	9. Inspection Guidance Used:
Ryan Craffey	02201	5	IP 87130

10. Licensee Contact Name(s):	11. Licensee E-mail Address:	12. Licensee Telephone Number(s):
Ray Carlson, MS - Consultant	rayacarlson@att.net	734-455-4730

13. Inspection Type:	14. Locations Inspected:	15. Next Inspection Date (MM/DD/YYYY):
☐ Initial ☑ Routine ☐ Announced ☐ Non-Routine ☑ Unannounced	☑ Main Office ☐ Field Office ☐ Temporary Job Site ☐ Remote	03/30/2027 ☑ Normal ☐ Extended ☐ Reduced ☐ No change

16. Scope and Observations:

This was a private medical clinic in Northville, Michigan, authorized to perform diagnostic administrations of radiopharmaceuticals. At the time of the inspection, one part-time nuclear medicine technologist performed 2-4 diagnostic administrations on Tuesdays and Wednesdays using unit doses from a licensed radiopharmacy. Nearly all administrations were for myocardial perfusion imaging (cardiac stress tests). The small remainder included a variety of general nuclear medicine studies. The licensee retained the services of a medical physics consultant to perform instrument calibrations and quarterly audits of the radiation safety program.

The inspector toured the clinic in Northville. Restricted areas were properly posted. Doses were kept in a locked cabinet inside the hot lab and imaging area; however, calibration sources and a hot sharps container (in total, slightly over 10x the aggregate 10 CFR 20 Appendix C quantity) were stored on top of the cabinet, behind lead. Although the west entrance to the building was adequately secured, an employee entrance to the right of that was unlocked at all times, potentially allowing unauthorized access to material were the technologist to leave the imaging room unlocked (as was often observed during the inspection) and fail to provide control and constant surveillance of the area (this was not observed). The inspector discussed the potential security vulnerability with the technologist, who committed to maintain control and constant surveillance of or else secure the hot lab and imaging area until she could discuss and implement a more robust security strategy with the licensee's consultant.

The inspector observed receipt of packages containing licensed material, instrument checks, and two cardiac stress tests using Tc-99m. The technologist was knowledgeable of radiation protection principles and regulatory requirements, and used adequate ALARA practices, calibrated and operable radiation detection instruments, and all required personnel dosimetry. The inspector noted that the technologist wore her ring badge only when required by procedure, i.e., during the preparation and handling of doses, as the adjustable band design of the dosimeter was difficult to wear under disposable gloves and prone to coming undone and falling off. The inspector reiterated these concerns to the licensee's consultant, who committed to discuss and review the matter with the technologist.

The inspector conducted independent and confirmatory surveys of the nuclear medicine department and found no exposures to members of the public above regulatory limits. The inspector found elevated radiation levels in the contents of a trash under a computer workstation not designated as radioactive waste. This waste had been present from the day before and was not identified by the technologist during previous surveys; however it was inside a restricted area, which cleaning personnel were prohibited from entering. The technologist disposed of the hot item (a discarded glove and/or its contents) in the hot trash, and confirmed that she surveyed all trash cans in restricted areas were prior to disposing of their contents, regardless of whether it was designated for radioactive waste.