

From: [Jefferson Fairbanks](#)
To: [Carol Hill](#); [R4 Licensing Action Submittals](#)
Subject: [External_Sender] St James License Renewal - Hospital Name Change
Date: Saturday, December 16, 2023 6:48:15 PM

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Carol, I received notification yesterday from Gary Bailey at St. James that the name of the hospital will change:

- Existing name on NRC license: "St James Healthcare"
- New name beginning January 29, 2024: "**Intermountain Health St. James Hospital**"

Will you kindly pass along to the person assigned for the license renewal to use the new name indicated above?

I have sent the License Renewal, and I received the Deemed Timely Letter from you on December 14, 2023:

- License Number: 25-13173-02
- Mail Control Number: 638279

Thank you,

Jeff



ACKNOWLEDGEMENT - RECEIPT OF CORRESPONDENCE

Name and Address of Applicant and/or Licensee

Jefferson Fairbanks, Ph.D.
Radiation Safety Officer
St. James Healthcare
400 South Clark Street
P.O. Box 3300
Butte, MT 59702

Date

01/08/2024

License Number(s)

25-13173-02

Mail Control Number(s)

638496

Licensing and/or Technical Reviewer or Branch

C. Hill

This is to acknowledge receipt of your: ☒ Letter and/or ☐ Application Dated: 12/16/2023

The initial processing, which included an administrative review, has been performed.

☒ Amendment ☐ Termination ☐ New License ☐ Renewal

☐ There were no administrative omissions identified during our initial review.

☐ This is to acknowledge receipt of your application for renewal of the material(s) license identified above. Your application is deemed timely filed, and accordingly, the license will not expire until final action has been taken by this office.

☐ Your application for a new NRC license did not include your taxpayer identification number. Please complete and submit NRC Form 531, Request for Taxpayer Identification Number, located at the following link: <http://www.nrc.gov/reading-rm/doc-collections/forms/nrc531.pdf>
Follow the instructions on the form for submission.

☐ The following administrative omissions have been identified:

Mr. Jefferson, I had to set this name change request up as a new action.

Your application has been assigned the above listed MAIL CONTROL NUMBER. When calling to inquire about this action, please refer to this control number. Your application has been forwarded to a technical reviewer. Please note that the technical review, which is normally completed within 180 days for a renewal application (90 days for all other requests), may identify additional omissions or require additional information. If you have any questions concerning the processing of your application, our contact information is listed below:

Region IV
U. S. Nuclear Regulatory Commission
DNMS/NMSB - B
1600 E. Lamar Boulevard
Arlington, TX 76011-4511
(817) 200-1103 or (817) 200-1140

BETWEEN:

Accounts Receivable/Payable
and
Regional Licensing Branches

[FOR ARPB USE]
INFORMATION FROM WBL

Program Code: 02240
Status Code: Pending Amendment
Fee Category: 7C
Exp. Date: 01/31/2024
Fee Comments: CODE 21
Decom Fin Assur Req: N

License Fee Worksheet - License Fee Transmittal

A. REGION

1. APPLICATION ATTACHED

Applicant/Licensee: St. James Healthcare
Received Date: 12/16/2023
Docket Number: 3012143
Mail Control Number: 638496
License Number: 25-13173-02
Action Type: Amendment

2. FEE ATTACHED

Amount: N/A

Check No.: N/A

3. COMMENTS

Signed: _____

Date: _____

B. LICENSE FEE MANAGEMENT BRANCH (Check when milestone 03 is entered / /)

1. Fee Category and Amount: _____

2. Correct Fee Paid. Application may be processed for:

Amendment: _____

Renewal: _____

License: _____

3. OTHER _____

Signed: _____

Date: _____

Agency: NRC

WBL WORKSHEET

DOCKET NUMBER: 3012143	LICENSE NUMBER: 25-13173-02	STATUS: Pending Amendment
MAIL CONTROL NUMBER: 638496	RECEIPT DATE: 12/16/2023	ACTION TYPE: Amendment
DUE DATE: 03/15/2024	INST. CODE: 13173	LICENSE REGION: Region 4
LICENSE TYPE: 30	ENTITY TYPE: C	LICENSE GROUP: Medical
ISSUE DATE:	ORIGINAL DATE: 08/06/1987	EXPIRATION DATE: 01/31/2024
DECOMMISSIONING CATEGORY: Group 1	LAST ISSUE DATE:	
LICENSEE NAME: St. James Healthcare	DECOM FIN ASSUR REQD: N SUBM: N	
MAILING ADDRESS LINE1: 400 South Clark Street	CONT PLAN REQD: N APPRV: N	
MAILING ADDRESS LINE 2: P.O. Box 3300		
CITY: Butte	STATE: MT	ZIP: 59702
CONTACT PERSON: PREFIX: Mr.	FIRST NAME: Gary	MIDDLE INITIAL:
LAST NAME: Bailey	SUFFIX:	
JOB TITLE: Sr. Director Imaging	PHONE: 406-723-2794 FAX:	EMAIL: gary.bailey@imail.org
BILLING ADDRESS LINE 1:		
BILLING ADDRESS LINE 2:		
CITY:	STATE: Montana	ZIP:
BILLING CONTACT PERSON: FIRST NAME:	MIDDLE INITIAL:	LAST NAME:
PHONE:	EMAIL:	FAX:
PRIMARY PGM CODE: 02240	SECONDARY PGM CODE: 02120	
INSPECTION REGION: Region 4	PRIORITY: 2	
RSO: PREFIX:	FIRST NAME: Jefferson	MIDDLE INITIAL: LAST NAME Fairbanks
SUFFIX: Ph.D	RSO JOB TITLE: Radiation Safety Officer	
RSO PHONE: 208-861-6501	RSO FAX:	RSO EMAIL: jfairbanks@radiationphysics.com
STATES WHERE USE IS AUTHORIZED: 1	0- ALL LISTED STATES 1- SAME AS STATE IN ADDRESS 2- ALL STATES 3- NON-AGREEMENT-STATES	
AUTHORIZED STATES (USE ONLY IF ABOVE IS ZERO):		