

NMSS Licensee Newsletter



**U.S. Nuclear
Regulatory
Commission**

**Office of Nuclear
Material Safety
and Safeguards**

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LICENSEE REPORTING FOR NUCLEAR MATERIALS MANAGEMENT AND SAFEGUARDS SYSTEM, NRC BULLETIN 2003-04

Presently, the U.S. Nuclear Regulatory Commission (NRC) requires certain NRC and Agreement State licensees and certificate holders (hereafter referred to as licensees) to submit data to the Nuclear Materials Management and Safeguards System (NMMSS) about their receipts, shipments, inventories, and changes in inventory of special nuclear material (SNM). Additionally, reporting is required for source material pursuant to meeting international treaty commitments (hereafter referred to as foreign obligated source material). The U.S. Department of Energy (DOE) has additional reporting requirements associated with other material types owned by the Government in licensee

possession (i.e., deuterium, tritium, curium, americium, neptunium, californium, berkelium, and enriched lithium).

In October 2001, the DOE Office of the Inspector General (OIG) issued a report entitled, "Accounting for Government-Owned Nuclear Materials Provided to Non-Department Domestic Facilities." Based on information available from NMMSS, one of the findings in the report was that DOE ". . . could not fully account for nuclear materials loaned or leased to domestic licensees." As a result of the OIG findings, NRC believes that NMMSS balances should be confirmed and corrected as necessary, on the basis of a one-time reporting of licensee material balances to NMMSS.

To accomplish that goal, NRC is requesting, through a Bulletin, that licensees submit, to NMMSS, current material balance information for SNM and foreign obligated source material. Additionally, licensees will be requested to report material balance information for other Government-owned material types in their possession. The Bulletin is available through the NRC public web page at: www.nrc.gov/reading-rm/doc-collections/gen-comm/bulletins/2003/b103004.pdf. Once those values are submitted to NMMSS, the NMMSS staff will compare the reported information to the NMMSS book values and assist licensees in the resolution of any NMMSS book discrepancies. Discrepancies that cannot be readily resolved may be referred to NRC for further action. However, it is not the intent of this effort to cite licensees for past reporting errors unless those errors demonstrate a deliberate act of non-compliance with regulations and/or negatively impacted the licensees' safety or safeguards controls.

All licensees, including those licensed pursuant to 10 CFR Part 30, should review the Bulletin to determine if it is applicable to their operations.

Licenseses may communicate directly with the NMMSS contractor or forward their questions to NRC via e-mail to nmmss@nrc.gov.

(Contact: Larry Harris, NSIR, 301-415-5072, e-mail: lchl@nrc.gov)

MEDICAL EVENTS CAUSED BY FAILURE TO PROPERLY MEASURE THE RADIOACTIVITY OF SAMARIUM-153 DOSAGES

Seven medical events were reported to the U.S. Nuclear Regulatory Commission (NRC), between November 2003 and January 2004, each involving licensee failure to properly measure the radioactivity of samarium-153 dosages with dose calibrators.

One medical event occurred when both a nuclear pharmacy and a medical licensee failed to properly measure the radioactivity of a samarium-153 unit dosage. During initial measurement of the dosage radioactivity, the nuclear pharmacy erroneously multiplied the dose-calibrator displayed radioactivity by a “10 factor.” However, the dose calibrator was set to display the actual radioactivity. Therefore, the nuclear pharmacy labeled the dosage vial to indicate 10 times the actual radioactivity before transfer to a medical licensee. When the medical licensee measured the dosage, it noted that the radioactivity displayed on its dose calibrator was approximately one-tenth of that on the vial label and the prescribed radioactivity on the written directive. The medical licensee contacted the nuclear pharmacy to discuss the discrepancy between the radioactivity measured with its dose calibrator and that indicated on the label. The nuclear pharmacy informed the technologist that a “10 factor” had to be applied to the radioactivity measured by the dose calibrator to obtain the actual radioactivity. The medical licensee applied the factor provided by the nuclear pharmacy and erroneously determined that the dosage contained the prescribed radioactivity, before administering it to a patient. As a result, the patient received approximately one-tenth of the prescribed samarium-153 radioactivity.

Six other medical events occurred because a medical licensee used an incorrect dose calibrator potentiometer setting during measurement of the radioactivity in samarium-153 dosages. As a result, the administered radioactivities were approximately 30 percent less than prescribed.

On June 12, 2002, NRC issued Information Notice (IN) 2002-19, “Medical Misadministrations caused by Failure to Properly Perform Tests on Dose

Calibrators for Beta- and Low-Energy Photon-Emitting Radionuclides.” The IN described the circumstances of medical misadministrations that occurred as a result of inaccurate radioactivity measurement of samarium-153 dosages and some of the potential sources of errors in measurement of beta- and low-energy gamma emitters. Based on the recent medical events described above, licensees are encouraged to review the IN and to verify that the radioactivities of beta- and low-energy gamma-emitting dosages are properly measured. This IN can be found on NRC’s website at <http://www.nrc.gov/reading-rm/doc-collections/gen-comm/info-notices/2002/in02019.pdf>.

(Contact: Robert G. Gattone, RIII/DNMS, 630-829-9823, e-mail: rgg@nrc.gov)

WHAT’S NEW ON THE MEDICAL USES LICENSEE TOOLKIT WEB PAGE

Nuclear Material Safety and Safeguards staff recently revised the “Medical Uses Licensee Toolkit: Regulations” section to add a link to the proposed rule “Recognition of Specialty Boards.” Although the public comment period has closed, this link can be used to review the draft proposed rule and the public comments. The “Medical Uses Licensee Toolkit: Other Guidance” section was revised to add licensing guidance for the Nucletron seedSelectron® System, Isotron brachytherapy sources, and Nucletron FIRST™ System, the newest 10 CFR 35.1000 medical use. The licensing guidance for the TheraSphere and SIRSphere Yttrium-90 Microspheres was revised to clarify use of the medical end-point of stasis in the written directive as a means of specifying when to terminate implantation of the microspheres. Also the “Notes to Licensee” section in the licensing guidance for each 10 CFR 35.1000 medical use was revised to inform licensees that they can apply for amendments that would permit them to make changes to their radiation safety programs, to conform with future revisions in the licensing guidance. These changes were made to inform licensees of current rulemaking activities or provide them with greater flexibility.

(Contact: Donna-Beth Howe, 301-415-7848, e-mail: dbh@nrc.gov)

SIGNIFICANT EVENTS

Event 1: Dose to Fetus

Date and Place: November 20, 2003; Hillcrest Hospital, Mayfield Heights, Ohio

Nature and Probable Causes: The Ohio Bureau of Radiation Protection reported that a 19-year-old female patient was administered 5.18 gigabecquerel (140.1 millicurie) of Iodine-131 for thyroid carcinoma as prescribed. The patient did not believe that she was pregnant and completed the required forms indicating that she was not pregnant before the dose was administered. On December 5, December 8, and December 11, 2003, quantitative tests confirmed that the patient was pregnant. The results were provided to her endocrinologist, who recommended that a fetal dose calculation be performed. The licensee's consultant informed the endocrinologist that the fetus would have received a whole body dose of 19.6 centigray (rad). The endocrinologist sent the results to the Center for Human Genetics at the University Hospital in Cleveland, Ohio, where an assessment determined that the pregnancy could safely continue.

Actions Taken to Prevent Recurrence

Licensee: The licensee has implemented pregnancy testing for child-bearing-age female patients receiving radiation therapy.

Event 2: Release of Uranium Hexafluoride

Date and Place: December 22, 2003, Metropolis, Illinois

Nature and Probable Causes: Honeywell International, Inc., reported an inadvertent release of uranium hexafluoride (UF⁶) that occurred on December 22, 2003. The release, which lasted approximately 45 minutes, went beyond the site boundary of Honeywell. The licensee declared a Site Area Emergency, and all persons within a 1.6-kilometer (1-mile) radius were evacuated. The local sheriff was notified and responded to the scene. Personnel from U.S. Nuclear Regulatory Commission (NRC) Headquarters and Region 2, NRC, also responded. The licensee estimated that approximately 3.2 kilograms (7 pounds) of UF⁶ were released. About 25 people offsite were temporarily evacuated, and some 75 persons remained sheltered for a time in their homes. Offsite air samples showed uranium levels up to 100 times that of normal levels, but at or below the NRC regulatory annual average effluent concentration limits. Urine bioassays from five members of the public were below public dose limits. Four members of the public reported to the hospital; three were examined and released, and the fourth was released after 24 hours.

NRC appointed an Augmented Inspection Team to inspect the circumstances surrounding the UF⁶ leak. The cause of this event was the assistant fluorine operator's failure to configure valves correctly, which caused a section of the piping to pressurize and leak. Contributing factors included the operator not having a procedure or checklist to designate the proper valve positions, no oversight nor review to ensure correct valve position, and the infrequent nature of this task.

Actions Taken to Prevent Recurrence

Licensee: Corrective actions were discussed at a public meeting held in NRC Headquarters on February 11, 2004.

(Contact: Angela Williamson, NMSS, 301-415-5030; e-mail: arw@nrc.gov)

ERRATA

Licensee: Rush Copley Medical Center, Aurora, Illinois.

Error: In the December 2003 edition of the *NMSS Licensee Newsletter*, a whole-body dose of 1587 centisievert (rem) was reported.

Correction: The preliminary whole-body dose of 1587 centisievert (rem) concerning Rush Copley Medical Center (as reported in the December 2003 edition of the *NMSS Licensee Newsletter*) has not been verified because of the pending question of preexisting hypothyroidism in the patient.

Licensee: Community Hospital of Anderson, Anderson Indiana.

Error: In the December 2003 edition of the *NMSS Licensee Newsletter*, this event was inappropriately categorized as a "misadministration."

Correction: For U.S. Nuclear Regulatory Commission (NRC) licensees, the term "misadministration" has been replaced by "medical event" in revised 10 CFR Part 35, "Medical Use of Byproduct Material." Furthermore, the licensee correctly reported this event, to NRC, as an unintended dose to the embryo/fetus, in accordance with 10 CFR 35.3047.

(Contact: Angela R. Williamson, NMSS, 301-415-5030; e-mail: arw@nrc.gov)

SIGNIFICANT ENFORCEMENT ACTIONS

The U.S. Nuclear Regulatory Commission's (NRC's) enforcement program can be accessed via NRC's homepage [<http://www.nrc.gov/>] under "What We Do." Documents related to cases can be accessed at [<http://www.nrc.gov/>], "Electronic Reading Room," "Documents in ADAMS." ADAMS is the Agency-wide Document Access and Management System. Help in using ADAMS is available from the NRC Public Document Room, telephone: 301-415-4737 or 1-800-397-4209.

Decommissioning

Westinghouse Electric Company, LLC (Hematite Facility) (EA-03-182)

On December 22, 2003, a Notice of Violation was issued for a Severity Level III violation involving two examples of the failure to follow enhanced work plans for decommissioning activities specific to the preparation of contaminated materials for shipping to a metal recycling facility.

Gauges

Imaging Subsurface, Inc. (EA-03-223)

On February 6, 2004, a Notice of Violation was issued for a Severity Level III violation involving the failure to secure from unauthorized removal, or limit access to, licensed material [nominally 296 megabecquerels (Mq) (8.0 millicuries (mCi)) of cesium-137 and 1480 MBq (40 mCi) of americium-241:beryllium, in two moisture-density gauges] in unrestricted areas at the licensee's facility, and failure to control and maintain constant surveillance of this licensed material.

Specifically, licensee staff left two unlocked moisture-density gauges unsecured and unattended in an unlocked storeroom at the licensee's facility.

Hannibal Testing Laboratories (EA-03-206)

On November 28, 2003, a Notice of Violation was issued for a Severity Level III violation involving the failure to secure from unauthorized removal, or limit access to, licensed material [nominally 296 megabecquerels (MBq) 8 millicuries (mCi) of cesium-137 and 1480 MBq (40 mCi) of americium-241:beryllium in two moisture-density gauges] in unrestricted areas at the licensee's facility, and failure to control and maintain constant surveillance

of this licensed material. Specifically, licensee staff left two unlocked moisture density gauges unsecured and unattended in two areas of the licensee's facility.

Medical

Union City Diagnostic Center (EA-03-170)

On January 13, 2004, a Notice of Violation was issued for a Severity Level III problem involving: (1) the receipt, possession, and use of byproduct material without the supervision of an Authorized User (AU) or a Radiation Safety Officer; and (2) the creation of false records indicating that the AU had ordered licensed material during that period, when, in fact, the AU was no longer employed at the facility.

Rice Memorial Hospital (EA-03-205)

On December 15, 2003, a Notice of Violation was issued for a Severity Level III violation involving the failure to secure from unauthorized removal, or limit access to, licensed material [approximately 5365 megabecquerels (MBq) (145 millicuries (mCi)) of technetium-99m and an approximate aggregate activity of 7104 Mq (192 mCi) of gadolinium-153 contained in sealed sources] in controlled areas, and the failure to control and maintain constant surveillance of the licensed material. Specifically, a technologist left the doors to a mobile nuclear van unlocked and unsecured when the technologist was in the client hospital and did not maintain constant surveillance of the licensed material located in the van.

Radiography

Cooperheat-MQS, Inc. (EA-03-151)

On December 30, 2003, a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$6000 was issued for a Severity Level III willful problem involving the failure to conduct required radiographer refresher training and the failure to provide complete and accurate information, to the U.S. Nuclear Regulatory Commission, involving radiographer-training records.

Individual Actions

Gary L. Youler (IA-03-036)

On December 30, 2003, a Notice of Violation was issued for a Severity Level III violation based on the

individual's deliberate activities while employed at Cooperheat-MQS, Inc. As the facility Radiation Safety Officer, the individual deliberately provided false information to the U.S. Nuclear Regulatory Commission, involving radiographer training records.

(Contact: Sally Merchant, 301-415-2747, e-mail: slm2@nrc.gov)

GENERIC COMMUNICATIONS ISSUED (September 29, 2003 - January 21, 2004)

The following are summaries of U.S. Nuclear Regulatory Commission (NRC) generic communications. If one of these documents appears relevant to your needs and you have not received it, please call one of the technical contacts listed below. The Internet address for the NRC library of generic communications is: <http://www.nrc.gov/reading-rm/doc-collections/gen-comm/index.html>. Please note that this address is case-sensitive and must be entered exactly as shown. If you have any questions or comments about generic communications in general, please contact Angela R. Williamson, NMSS, at (301) 415-5030, or by e-mail: arw@nrc.gov.

Bulletin (BL)

No bulletins have been issued, to date, in 2004.

Information Notices (INs)

IN 2003-17, "Reduced Service Life of Automatic Switch Company (ASCO) Solenoid Valves with Buena-n Material," was issued on September 29, 2003. This IN was sent to all holders of operating licenses for nuclear power reactors, to apprise them of potential problems caused by the hardening of Buena-n material used in fabricating solenoid valves manufactured by ASCO.

(Technical Contacts: Thomas Koshy, NRR, 301-415-1176, e-mail: txk@nrc.gov; Matthew W. McConnell, NRR, 301-415-1597, e-mail: mxm4@nrc.gov; and Jerry Dozier, NRR, 301-415-1176, e-mail: jxd@nrc.gov).

IN 2003-18, "General Electric Type SBM Control Switches with Defective Cam Followers," was issued on September 26, 2003. This IN was sent to all holders of operating licenses for nuclear power reactors, except those that have permanently ceased operations and have certified that fuel has been permanently removed from the reactor vessel. This IN was sent to inform addressees of recent and long-term operational experience, with control switches

and relays incorporating a polycarbonate plastic material, known as Lexan, manufactured by General Electric.

(Technical contacts: Vernon Hodge, NRR, 301-415-1861, e-mail: cvh@nrc.gov; Stephen Alexander, NRR, 301-415-2995; e-mail: sda@nrc.gov; and Joe O'Hara, Region I, 410-495-4669, e-mail: jmo@nrc.gov).

IN 2003-19, "Unanalyzed Condition of Reactor Coolant Pump Seal Leakoff Line During Postulated Fire Scenarios or Station Blackout," was issued October 6, 2003. This IN was sent to all holders of operating licenses or construction permits for pressurized-water reactors. This IN was issued to alert addressees to recent identification of an unanalyzed condition involving the design of the reactor coolant pump seal leakoff line.

(Technical contacts: Paul Cataldo, Region I, 860-701-3470, e-mail: pcc1@nrc.gov; Warren Lyon, NRR, 301-415-2897, e-mail: wcl@nrc.gov; and Phil Qualls, NRR, 301-415-1849, e-mail: pmq@nrc.gov)

IN 2003-21, "High-Dose-Rate-Remote-Afterloader Equipment Failure," was issued November 24, 2003. This IN was issued to inform addressees of a recently reported medical event that occurred during the conduct of a high-dose-rate, remote-afterloader brachytherapy procedure.

(Technical contact: Ronald Zelac, PhD, 301-415-7635, e-mail: rez@nrc.gov)

IN 2003-22, "Heightened Awareness for Patients Containing Detectable Amounts of Radiation from Medical Administrations," was issued December 9, 2003. This IN was issued to inform addressees of an event where a radiation detector, installed as part of heightened homeland security measures, alarmed when a recently released radiopharmaceutical patient passed by it.

(Technical contacts: Teresa Darden, Region I, 610-337-5245, e-mail: thd@nrc.gov; Pamela J. Henderson, Region I, 610-337-6952, e-mail: pjh1@nrc.gov; and Donna-Beth Howe, PhD, NMSS, 301-415-7848, e-mail: dbh@nrc.gov)

IN 2004-01, "Auxiliary Feedwater Pump Recirculation Line Orifice Fouling - Potential Common-Cause Failure," was issued January 21, 2004. This IN was issued to all holders of operating licenses or construction permits for nuclear power reactors, except those that have permanently ceased

operations and have certified that fuel has been permanently removed from the reactor vessel. This IN was issued to inform addressees of the potential common-cause failure of auxiliary feedwater pumps because of fouling of pump-recirculation line-flow orifices.

(Technical contacts: Jerry Dozier, NRR, 301-415-1176, e-mail: jxd@nrc.gov; Paul Krohn, Region III, 920-755-2309, e-mail: pgk1@nrc.gov)

Regulatory Issue Summaries (RIS')

RIS 2003-18, "Use of NEI 99-01 - Methodology for Development of Emergency Action Levels," Revision 4, dated January 2003, was issued on October 08, 2003. This RIS was issued to all holders of operating licenses for nuclear power reactors and licensees that have permanently ceased operations and have certified that fuel has been permanently removed from the reactor vessel. This RIS was issued to inform addressees that the U.S. Nuclear Regulatory Commission (NRC) has reviewed Nuclear Energy Institute 99-01 - "Methodology for Development of Emergency Action Levels," Revision 4, January 2003, and is endorsing the report for use as guidance in developing or changing a standard emergency-classification and action-level scheme. In addition, this RIS provides recommendations to help licensees determine whether to seek prior NRC approval of deviations from the new guidance. (Technical contact: Thomas Blount, NRR, 301-415-1501, e-mail: txb1@nrc.gov)

(General Contact: Angela R. Williamson, NMSS, 301-415-5030, e-mail: arw@nrc.gov)

SELECTED FEDERAL REGISTER NOTICES (December 1, 2003 - February 29, 2004)

NOTE: U.S. Nuclear Regulatory Commission (NRC) contacts may be reached by mail at the U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001.

FINAL RULES

"List of Approved Spent Fuel Storage Casks: Standardized NUHOMS 24P, 52B, 61BT, and 24PHB Revision (Amendment 6); Correction and Confirmation of Effective Date," 68 FR 70121, December 17, 2003.

(Contact: Margaret Stambaugh, NMSS, 301-415-5449, e-mail: mxs8@nrc.gov)

"List of Approved Spent Fuel Storage Casks: Standardized NUHOMS 24P, 52B, 61BT, 32PT, and 24PHB Revision (Amendment 7); Direct Final Rule," 68 FR 70423, December 18, 2003.

(Contact: Jayne M. McCausland, NMSS, 301-415-6219, e-mail: jmm2@nrc.gov)

"List of Approved Spent Fuel Storage Casks: Standardized NUHOMS-24P, -52B, -61BT, -24PHB, and -32 PT, Revision 5," 69 FR 849, January 7, 2004.

(Contact: Jayne M. McCausland, NMSS, 301-415-6219, e-mail: jmm2@nrc.gov)

"Changes to Adjudicatory Process," 69 FR 2182, January 14, 2004.

(Contact: Geary S. Mizuno, OGC, 301-415-1639, e-mail: gsm@nrc.gov)

"List of Approved Spent Fuel Storage Casks: NAC-UMS Revision," 69 FR 2497, January 16, 2004.

(Contact: Jayne M. McCausland, NMSS, 301-415-6219, e-mail: jmm2@nrc.gov)

"Compatibility with IAEA Transportation Safety Standards and Other Transportation Safety Amendments: **Correction**," 69 FR 6139, February 10, 2004.

(Contact: Naiem S. Tanius, NMSS, 301-415-6103, e-mail: nst@nrc.gov)

PROPOSED RULES

"Medical Use of Byproduct Material-Recognition of Specialty Boards," 68 FR 68549, December 9, 2003.

(Contact: Roger W. Broseus, NMSS, 301-415-7608, e-mail: rwb@nrc.gov)

"List of Approved Spent Fuel Storage Casks: Standardized NUHOMS 24P, 52B, 61BT, 32PT, and 24PHB Revision (Amendment 7); Companion Proposed Rule," 68 FR 70463, December 18, 2003.

(Contact: Jayne M. McCausland, NMSS, 301-415-6219, e-mail: jmm2@nrc.gov)

"List of Approved Spent Fuel Storage Casks: NAC-UMS Revision (companion proposed rule)," 69 FR 2528, January 16, 2004.

(Contact: Jayne M. McCausland, NMSS, 301-415-6219, e-mail: jmm2@nrc.gov)

“Revision of Fee Schedules; Fee Recovery for FY 2004,” 69 FR 4865, February 2, 2004.

(Contacts: Ann Norris, OCFO, 301-415-7807, e-mail: ame@nrc.gov; Tammy Croote, OCFO 301-415-6041, txc1@nrc.gov)

OTHER NOTICES

“Revision of NRC Enforcement Policy; Packaging and Transportation of Radioactive Material (NUREG-1600),” 69 FR 385, January 5, 2004. (Contact: Frank J. Congel, OE, 301-415-2741, e-mail: fjc@nrc.gov)

“Draft Regulatory Guide-7003 (Proposed Revision 2 of Regulatory Guide 7.9), ‘Standard Format and Content of Part 71 Applications for Approval of Packaging for Radioactive Material,’ “ 69 FR 2014, January 13, 2004.

(Contact: N.L. Osgood, NMSS, 301-415-8513, e-mail: nlo@nrc.gov)

“Hazardous Materials Regulations; Compatibility with the Regulations of the International Atomic Energy Agency,” 69 FR 3632, January 26, 2004.

(Contact: Naiem S. Tanious, NMSS, 301-415-6103, e-mail: nst@nrc.gov)

“Order Imposing Additional Security Measures” (Effective Immediately), 69 FR 5733, February 4, 2004.

“State of Utah: NRC Staff Draft Assessment of a Proposed Amendment to Agreement Between the Nuclear Regulatory Commission and the State of Utah” (**First printing**), 69 FR 7026, February 12, 2004.

(Contact: Dennis M. Sollenberger, OSTP, 301-415-2819, e-mail: dms4@nrc.gov)

“State of Utah: NRC Staff Draft Assessment of a Proposed Amendment to Agreement Between the

Nuclear Regulatory Commission and the State of Utah” (**Reprint**), 69 FR 7803, February 19, 2004.

(Contact: Dennis M. Sollenberger, OSTP, 301-415-2819, e-mail: dms4@nrc.gov)

“Collection, Reporting, or Posting of Information; **Availability of Draft Rule Language**,” 69 FR 8350, February 24, 2004.

(Contact: William D. Reckley, NRR, 301-415-1323, e-mail: wdr@nrc.gov)

“State of Utah: NRC Staff Draft Assessment of a Proposed Amendment to Agreement Between the Nuclear Regulatory Commission and the State of Utah” (**Reprint**), 69 FR 8703, February 25, 2004.

(Contact: Dennis M. Sollenberger, OSTP, 301-415-2819, e-mail: dms4@nrc.gov)

“Issuance, Availability of Draft Regulatory Guide, DG-7004, ‘Standard Format and Content of Part 71 Applications for Approval of Packaging for Radioactive Material,’ “ 69 FR 8706, February 25, 2004.

(Contact: J. Pearson, NMSS, 301-415-1985, e-mail: jjp@nrc.gov)

(General Contact: Michael Williamson, NMSS, 301-415-6234, e-mail: mkw1@nrc.gov)

Comments , and suggestions you may have for information not currently included, that might be helpful to licensees, should be sent to:

E. Kraus, Editor
NMSS Licensee Newsletter
Office of Nuclear Material Safety and Safeguards
Two White Flint North, Mail Stop 8-A-23
U.S. Nuclear Regulatory Commission
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