UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
1600 E. LAMAR BLVD
ARLINGTON, TX 76011-4511

January 13, 2017

EA-16-191

Ms. Shelly Sayer
Chief Executive Officer
Premier Technology, Inc.
1858 W. Bridge Street
Blackfoot, ID 83221

SUBJECT: NRC INSPECTION REPORT 030-36173/2015-001 AND 030-36173/2016-001

Dear Ms. Sayer:

This letter refers to the routine, unannounced inspections conducted on May 19 and 22, 2015, and July 14, 2016, at your facility in Blackfoot, Idaho. The purpose of the inspections was to examine activities conducted under your license as they relate to public health and safety and to confirm compliance with the U.S. Nuclear Regulatory Commission's (NRC's) rules and regulations and with the conditions of your license. Within these areas, the inspections consisted of examinations of selected procedures and representative records, observations of licensed activities, independent radiation measurements, and interviews with personnel. On May 19 and 22, 2015, the preliminary inspection findings were discussed with Mr. Mathew Burke and Mr. Darrin Carter of your staff. On July 14, 2016, the preliminary inspection findings of the second inspection were discussed with you and Mr. Douglas Sayer. A final exit briefing was conducted telephonically with Mr. Doug Sayer, Mr. Jared Whitehead, Mr. Caleb Killian, and you on November 30, 2016. The enclosed report presents the results of the inspections.

Based on the results of the inspection, a number of apparent violations were identified and are being considered for escalated enforcement action in accordance with the NRC Enforcement Policy. The current Enforcement Policy is included on the NRC Web site at http://www.nrc.gov/about-nrc/regulatory/enforcement/enforce-pol.html. The apparent violations being considered for escalated enforcement action involve failures to: (1) read and record pocket dosimeter exposures at the beginning and end of each shift as required by Title 10 of the *Code of Federal Regulations* (10 CFR) 34.47(b); (2) require that an individual acting as a radiographer wear on the trunk of the body, an operating alarm ratemeter as required by 10 CFR 34.47(a); (3) use alarm ratemeters that were set to give an alarm signal at a preset dose rate of 5 mSv/hr (500 mrem/hr) as required by 10 CFR 34.47(g)(2); and (4) transport hazardous material by highway with shipping papers prepared in accordance with 49 CFR Part 172. One or more apparent violations involving security requirements are discussed in non-public Attachment 2 of the Enclosure.

Attachment 2 of the Enclosure contains Sensitive Unclassified Non-Safeguards Information. When separated from Attachment 2, this letter and the Enclosure are decontrolled.

The circumstances surrounding these apparent violations, the significance of the issues, and the need for lasting and effective corrective action were discussed with you and members of your staff at the conclusion of the onsite portions of the inspections, and during the final exit briefing on November 30, 2016.

Since the NRC has not made a final determination in this matter, a Notice of Violation is not being issued for these inspection findings at this time. In addition, please be advised that the number and characterization of apparent violations described in the enclosed inspection report may change as a result of further NRC review.

In addition, since your facility has not been the subject of escalated enforcement actions within the past two inspections, and based on our understanding of your corrective actions, a civil penalty may not be warranted in accordance with Section 2.3.4 of the Enforcement Policy. The final decision will be based on you confirming on the license docket (i.e., in writing) that the short-term corrective actions previously described to the NRC staff have been or are being taken and any corrective actions that you plan to take to better assure a long-term duration of compliance and safety.

Before the NRC makes its enforcement decision, we are providing you an opportunity to: (1) respond, in writing, to the apparent violations addressed in this inspection report within 30 days of the date of this letter; (2) request a predecisional enforcement conference (PEC); or (3) request Alternative Dispute Resolution (ADR). If a PEC is held, the NRC will issue a meeting notice to announce the time and date of the conference; however, the PEC will be closed to public observation since Security-Related Information will be discussed and the report has not been made public. If you decide to participate in a PEC or pursue ADR, please contact Mr. Ray L. Kellar, P.E., Chief, Nuclear Materials Safety Branch A, at 817-200-1191, within 10 days of the date of this letter to notify the NRC of your intended response. A PEC should be held within 30 days and an ADR session within 45 days of the date of this letter.

If you choose to provide a written response, it should be clearly marked as a “Response to an Apparent Violation, NRC inspection Report 030-36173/2015-001 and 030-36173/2016-001; EA-16-191” and should include for each of the apparent violations: (1) the reason for the apparent violation or, if contested, the basis for disputing the apparent violation; (2) the corrective steps that have been taken and the results achieved; (3) the corrective steps that will be taken; and (4) the date when full compliance will be achieved. Your response may reference or include previously docketed correspondence, if the correspondence adequately addresses the required response. Additionally, your response should be sent to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555 0001, with a copy to the Director, Division of Nuclear Materials Safety, U.S. Nuclear Regulatory Commission, Region IV, 1600 E. Lamar Blvd., Arlington, TX 76011-4511.

If an adequate response is not received within the time specified or an extension of time has not been granted by the NRC, the NRC will proceed with its enforcement decision or schedule a PEC. Please be advised that the number and characterization of apparent violations described in the enclosed report may change as a result of further NRC review. You will be advised by separate correspondence of the results of our deliberations on this matter.

If you choose to request a PEC, the conference will afford you the opportunity to provide your perspective on these matters and any other information that you believe the NRC should take into consideration before making an enforcement decision. The decision to hold a PEC does not mean that the NRC has determined that a violation has occurred or that enforcement action will be taken. This conference would be conducted to obtain information to assist the NRC in making an enforcement decision. The topics discussed during the conference may include information to determine whether a violation occurred, information to determine the significance of a violation, information related to the identification of a violation, and information related to any corrective actions taken or planned.

In presenting your corrective actions, you should be aware that the promptness and comprehensiveness of your actions will be considered in assessing any civil penalty for the apparent violations. The guidance in NRC Information Notice 96-28, "Suggested Guidance Relating to Development and Implementation of Corrective Action," may be helpful. You can find the Information Notice on the NRC Web site at http://pbadupws.nrc.gov/docs/ML0612/ML061240509.pdf.

In lieu of a PEC, you may request ADR with the NRC in an attempt to resolve this issue. ADR is a general term encompassing various techniques for resolving conflicts using a neutral third party. The technique that the NRC has decided to employ is mediation. Mediation is a voluntary, informal process in which a trained neutral mediator works with parties to help them reach resolution. If the parties agree to use ADR, they select a mutually agreeable neutral mediator who has no stake in the outcome and no power to make decisions. Mediation gives parties an opportunity to discuss issues, clear up misunderstandings, be creative, find areas of agreement, and reach a final resolution of the issues. Additional information concerning the NRC's program can be obtained at http://www.nrc.gov/about-nrc/regulatory/enforcement/adr/post-investigation.html. Cornell University's Scheinman Institute on Conflict Resolution (Cornell) has agreed to facilitate the NRC's program as a neutral third party. Please contact Cornell at 877-733-9415 within 10 days of the date of this letter if you are interested in pursuing resolution of this issue through ADR.

In accordance with 10 CFR 2.390, of the NRC's "Agency Rules of Practice and Procedure," a copy of this letter and Attachment 1 of the Enclosure will be made available electronically for public inspection in the NRC Public Document Room or in the NRC's Agencywide Documents Access and Management System (ADAMS), accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html. However, Attachment 2 of the Enclosure contains Security-Related Information in accordance with 10 CFR 2.390(d)(1) and its disclosure to unauthorized individuals could present a security vulnerability. Therefore, Attachment 2 will not be made available electronically for public inspection in the NRC Public Document Room or from the NRC's ADAMS.

If you choose to provide a response and Security-Related Information is necessary to provide an acceptable response, please mark your entire response "Security-Related Information – Withhold from public disclosure under 10 CFR 2.390" in accordance with 10 CFR 2.390(b)(1) and follow the instructions for withholding in 10 CFR 2.390(b)(1). In accordance with 10 CFR 2.390(b)(1)(ii), the NRC is waiving the affidavit requirements for your response.

If you have any questions concerning this matter, please contact Mr. Ray L. Kellar, P.E., of my staff at 817-200-1191.

Sincerely,

/RA/

Mark R. Shaffer, Director
Division of Nuclear Materials Safety

Docket No. 030-36173
License No. 11-27746-01

Public Enclosure:
NRC Inspection Report 030-36173/2015-001
and 030-36173/2016-001 w/attachment 1

Non-Public Enclosure:
Attachment 2 of the NRC Inspection Report 030-36173/2015-001
and 030-36173/2016-001

cc w/Enclosure: Mark Dietrich, Administrator
Technical Services Division
1410 North Hilton
Boise, ID 83706

If you have any questions concerning this matter, please contact Mr. Ray L. Kellar, P.E., of my staff at 817-200-1191.

Sincerely,

/RA/

Mark R. Shaffer, Director
Division of Nuclear Materials Safety

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cc w/Enclosure: Mark Dietrich, Administrator
Technical Services Division
1410 North Hilton
Boise, ID 83706

DISTRIBUTION:

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RidsEdoMailCenter Resource;	EDO_Managers;	RidsOcfoMailCenter Resource;
RidsOiMailCenter Resource;	RidsRgn1MailCenter Resource;	RidsRgn3MailCenter Resource;

ADAMS ACCESSION NUMBER – **PUBLIC LETTER AND IR W/O ATTACHMENT 2: ML17013A616**
ADAMS ACCESSION NUMBER – **NON-PUBLIC LETTER W/ATTACHMENT 2: ML16314A920**

Cover Letter (w/o Att 2) **X** SUNSI Review by: **JFK**	ADAMS **X** Yes ☐ No	**X** Publicly Available ☐Non-Publicly Available	**X** Non-Sensitive ☐Sensitive	Keyword: EA-16-191
Cover Letter (w/Att 2) **X** SUNSI Review by: **JFK**	ADAMS **X** Yes ☐ No	☐ Publicly Available **X Non-Publicly Available**	☐ Non-Sensitive **X Sensitive**	Keyword: MD A.3

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U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket No:	030-36173
License No:	11-27746-01
Report Nos:	030-36173/2015-001 030-36173/2016-001
EA No:	EA-16-191
Licensee:	Premier Technology, Inc.
Facility:	1858 W. Bridge Street Blackfoot, Idaho
Inspection Dates:	May 19 and 22, 2015, and July 14, 2016
Exit Meeting Date:	November 30, 2016
Inspector:	Janine F. Katanic, PhD, CHP Senior Health Physicist Nuclear Materials Safety Branch A
Approved by:	Ray L. Kellar, P.E., Chief Nuclear Materials Safety Branch A Division of Nuclear Materials Safety

Enclosure

EXECUTIVE SUMMARY

Premier Technology, Inc.
NRC Inspection Report 030-36713/2015-001 and 030-36713/2016-001

Program Overview

Premier Technology, Inc., is authorized to possess and use byproduct material (Iridium-192) for industrial radiographic operations at its facility in Blackfoot, Idaho, and at temporary job sites in areas of NRC jurisdiction.

Inspection Findings

During two routine, unannounced inspections conducted on May 19 and 22, 2015, and July 14, 2016, four apparent violations of NRC requirements related to health and safety were identified. The apparent violations involve the licensee's failures to: (1) ensure pocket dosimeters were read and the exposures recorded at the beginning and end of each shift; (2) have a person acting as a radiographer wear an operating alarm ratemeter at all times during radiographic operations; (3) have each alarm ratemeter set to give an alarm signal at a preset dose rate of 5 mSv/hr (500 mrem/hr); and (4) have shipping papers when transporting hazardous (radioactive) material by public highway. (Attachment 1)

In addition, one or more apparent violation(s) of NRC security requirements were identified. These apparent violation(s) are discussed in the non-public attachment to this report. (Attachment 2)

Corrective Actions

During the inspection, the licensee performed actions to address the issues identified during the inspection with regard to radiation safety, the transportation of radioactive materials, and implementation of the security requirements in 10 CFR Part 37. On May 19, 2015, and at the conclusion of the onsite portion of the inspection, the licensee performed several immediate corrective actions and compensatory measures. Many corrective actions were confirmed by the inspector on May 22, 2015. The comprehensiveness of the corrective actions to prevent recurrence of the violations was reviewed during the July 14, 2016, inspection.

REPORT DETAILS – Health and Safety

1 Program Overview (Inspection Procedure 87121)

1.1 Program Scope

Premier Technologies, Inc. is a company with headquarters in Blackfoot, Idaho, which offers full-service engineering, manufacturing, and construction management services for private sector and government clients. Premier Technologies, Inc. is authorized under NRC byproduct materials license 11-27746-01 to possess and use byproduct material (iridium-192) for industrial radiographic operations. Licensed activities are authorized at the licensee's facility located in Blackfoot, Idaho, as well as at temporary job sites in areas of NRC jurisdiction. The licensee has a small radiography crew that performs mainly in-house radiographic activities in a shielded vault in the licensee's facility. The main radiography crew consists of the radiation safety officer (RSO) and another experienced radiographer. Other employees are trained radiographers but do not regularly participate in licensed activities. Nearly all of the radiographic activities are conducted in a shielded concrete vault located at the licensee's facility or are conducted within the confines of the licensee's facility. The licensee occasionally conducted radiographic operations at a temporary job site at a facility in Idaho Falls, Idaho.

1.2 Observations and Findings

The inspector reviewed the licensee's operations and written procedures and interviewed the RSO and the assistant radiographer regarding the performance of industrial radiography and transportation of radioactive materials as they relate to public health and safety to confirm compliance with the NRC's rules, regulations, and the conditions of the NRC license. Collectively, the activities observed and the documents reviewed describe the licensee's implementation of its radiation safety program.

2 Inspection Findings (Inspection Procedure 87121)

2.1 Inspection Scope

Routine, unannounced inspections were conducted on May 19 and 22, 2015, and July 14, 2016, at the licensee's Blackfoot, Idaho facility. The inspector interviewed the RSO, assistant radiographer, and Quality Assurance Manager, and reviewed records and procedures related to the licensee's implementation of its radiation safety program.

2.2 Observation and Findings

On May 19, 2015, when the inspector arrived at the licensee's facility, it was determined that the radiographers (RSO and assistant radiographer) had returned from performing radiographic operations overnight at a temporary job site in Idaho Falls. The inspector interviewed the radiographers, reviewed the equipment that was used by the radiographers during the licensed activities, and reviewed documents related to the licensed activities.

Four apparent violations of NRC health and safety requirements were identified. The apparent violations are described below.

Apparent violation of Title 10 of the Code of Federal Regulations (10 CFR) 34.47(b)

Title 10 of the *Code of Federal Regulations* (10 CFR) 34.47(b) states that direct reading dosimeters such as pocket dosimeters or electronic personal dosimeters, must be read and the exposures recorded at the beginning and end of each shift.

The inspector's review of the equipment that was used by the RSO and assistant radiographer during radiographic operations conducted at a temporary job site revealed that a pocket dosimeter that was worn by one of the radiographers was observed to have no fiber indicator visible along the scale. The individual was asked to read the dose from the pocket dosimeter and he said that the dose was zero. The inspector asked the RSO to charge the dosimeter. After the pocket dosimeter was charged, the inspector looked at the dosimeter to read the dose and observed the fiber indicator moving rapidly (in less than 30 seconds) from zero to completely off-scale, resulting in the fiber no longer being visible along the scale, a condition sometimes referred to as "excessive drift." The pocket dosimeter was then recharged and observed by the RSO, with the same results of the fiber quickly going off scale and no longer being visible. The pocket dosimeter had been worn by the one of the radiographers during the radiographic operations. Had the licensee recharged and read the pocket dosimeter at the beginning of the shift, it would have been apparent that the pocket dosimeter was not operational due to the excessive drift. Additionally, had the licensee read the pocket dosimeter at the end of the shift, and observed it to be off-scale, the licensee would have needed to take further action in accordance with 10 CFR 34.47(d) for a possible overexposure. It was explained by the RSO that, at the temporary job site, he asked the radiographer for the pocket dosimeter readings. The values given for the beginning and end of the shift were stated to be zero. However, the radiographer indicated that the dosimeter was not read at the beginning and end of the shift.

Apparent violation of 10 CFR 34.47(a)

10 CFR 34.47(a) states, in part, that a licensee may not permit any individual to act as a radiographer or a radiographer's assistant unless, at all times during radiographic operations, each individual wears, on the trunk of the body, a direct reading dosimeter, an operating alarm ratemeter, and a personnel dosimeter.

The inspector's review of the equipment that was used by the RSO and assistant radiographer during radiographic operations conducted at a temporary job site revealed that the radiographers were using the Sentinel RadEyeG as both an alarm ratemeter and a survey meter during radiographic operations. The individuals' practice was to remove the alarm ratemeter from the trunk of the body during radiographic operations because the alarm ratemeter was also used by the radiographers as a hand-held radiation survey instrument to fulfill the radiation survey requirements of 10 CFR 34.49.

The alarm ratemeter is required to be used by 10 CFR 34.47(a) whereas the requirement to conduct surveys with a survey instrument is required by 10 CFR Part 34.49. An alarm ratemeter is required to be worn on the trunk of the body whereas surveys that are required by 10 CFR 34.49 must be made of the exposure device and guide tube, necessitating a hand-held survey instrument that can be observed by the radiographer while performing the survey. In this case, the Sentinel RadEyeG was being used by the licensee as an alarm ratemeter and also to perform

required surveys. It would therefore have been removed from the trunk of the body to perform the survey, thus it would no longer meet the requirements of 10 CFR Part 34.47(a). The radiographers expressed that they thought that because the Sentinel RadEyeG was capable of performing both functions, it could be used to fulfill both functions (alarm ratemeter and survey instrument).

Apparent violation of 10 CFR 34.47(g)(2)

10 CFR 34.47(g)(2) states, in part, that each alarm ratemeter must be set to give an alarm signal at a preset dose rate of 5 mSv/hr (500 mrem/hr).

The inspector reviewed the equipment that was used by the RSO and assistant radiographer during the conduct of radiographic operations at a temporary job site. The inspector reviewed the alarm set points of the radiographer's and assistant radiographer's alarm ratemeters, both Sentinel RadEyeG's. One radiographer's alarm ratemeter had the alarm set point correctly set to 5 mSv/hr (500 mrem/hr). The other radiographer's alarm ratemeter was set to alarm at 100 mSv/hr (10 R/hr). When this was pointed out to the RSO, he stated that he assumed that when the instruments were calibrated, the vendor would set the alarm to default at 5 mSv/hr (500 mrem/hr), and he was unaware that this alarm set point could be changed by the user. Although these instruments have the capability to have the alarm set points locked by the vendor such that they cannot be changed, that was not the case for either piece of equipment observed. It could not be established when the alarm ratemeter was set to alarm at 100 mSv/hr (10 R/hr), so it is unknown how long this non-compliance existed.

Apparent violation of 10 CFR 71.5(a)

License Condition 18 of NRC License 11-27746-01, Amendment No. 10, states that the licensee is authorized to transport licensed material in accordance with the provisions of 10 CFR Part 71, "Packaging and Transportation of Radioactive Material." 10 CFR 71.5(a) states, in part, that each licensee who transports licensed material outside of the site of usage, as specified in the NRC license, or where transport is on public highways, shall comply with the applicable requirements of the U.S. Department of Transportation regulations in 49 CFR Parts 107, 171 through 180, and 390 through 397, appropriate to the mode of transport. 49 CFR 177.817(a) states, in part, that a person may not transport a hazardous material by highway unless that person has received a shipping paper prepared in accordance with 49 CFR Part 172.

When further reviewing licensed activities related to the radiography performed at the temporary job site in Idaho Falls, the inspector asked to see the shipping papers for the transport of the radiography camera containing iridium-192 from its storage location in Blackfoot to the temporary job site in Idaho Falls. The RSO stated that he was unaware of the requirement for having shipping papers. The recent radiographic activities in Idaho Falls were the first time that the licensee had performed radiography outside of its main facility. The licensee had performed radiography a few times in Idaho Falls for one client, which was not a normal practice. As a result, the licensee transported Class 7 (radioactive) hazardous materials by public highways on at least five occasions between February 26, 2015, and May 18, 2015, and did not have properly prepared required shipping papers.

2.3 Conclusions

Four apparent violations of NRC health and safety requirements were identified, involving the licensee's failures to: (1) ensure pocket dosimeters were read and the exposures recorded at the beginning and end of each shift in accordance with 10 CFR 34.47(b); (2) have a person acting as a radiographer wear an operating alarm ratemeter at all times during radiographic operations in accordance with 10 CFR 34.47(a); (3) have each alarm ratemeter set to give an alarm signal at a preset dose rate of 5 mSv/hr (500 mrem/hr) in accordance with 10 CFR 34.47(g)(2); and (4) have shipping papers when transporting hazardous (radioactive) material by highway, in accordance with 49 CFR Part 172.

The causal factors related to the health and safety apparent violations included: (1) the radiography crew's misunderstanding that the RadEyeG could be used to fulfill two functions (alarm ratemeter and survey instrument); (2) the radiographer's misunderstanding that if the fiber was not visible on the pocket dosimeter then the reading was "zero," rather than potentially off-scale due to excessive drift, and (3) the assumption that the alarm ratemeter function would be set by the vendor to a default alarm of 5 mSv/hr (500 mrem/hr). A contributing factor was that the radiography crew was accustomed to zero dose on their pocket dosimeters because they normally performed radiography within a shielded vault and had grown complacent with repeatedly observing no dose recorded on their pocket dosimeters. The radiographers did not adjust their radiation safety behaviors when working at a temporary job site at a client facility. The inspector observed that the licensee had multiple extra and backup equipment, including extra pocket dosimeters, dedicated alarm ratemeters, and additional hand-held radiation survey instrumentation, but all of this extra equipment was at the Blackfoot facility and was not taken to the client facility in Idaho Falls because they were not accustomed to performing off-site work. Because they were not accustomed to transporting a radiographic camera, it was transported without the required shipping papers.

The apparent violations represent a serious safety deficiency. Having a non-functional pocket dosimeter prevents the radiographer from being able to have a direct-read of accumulated dose during radiographic operations. Had there been an incident, there would have been no immediately available indication of the individual's dose. Although one individual had an alarm ratemeter set to the correct alarm value, the other individual's alarm ratemeter was set to alarm at 100 mSv/hr (10 R/hr). With a higher alarm set point, the radiographer would have had to be much closer to the source before observing an alarm, and as a result, would have potentially been exposed to additional radiation dose than had the alarm been set to the required set point. The individual with the non-functional pocket dosimeter with excessive drift is the same individual with the alarm ratemeter with the incorrect alarm set point. The alarm ratemeter was also being used as a survey meter, which precludes redundancy should this piece of equipment fail. The radiation safety practices utilized were poor and could have led to radiological consequences.

3 Corrective Actions

At the conclusion of the inspection conducted on May 19, 2015, the RSO immediately took the broken pocket dosimeter out of service and tagged it as inoperable. Additionally, the radiographers gathered the additional survey instruments that could be used as hand-held radiation survey instruments so that they would not need to use the alarm ratemeter as a survey meter. The RSO re-set the alarm ratemeter to the appropriate alarm set point of 5 mSv/hr (500 mrem/hr). The RSO committed to develop and utilize shipping papers for transporting Class 7 (radioactive) hazardous materials by public highway.

The inspector returned to the facility on May 22, 2015, and confirmed that both pocket dosimeters used by the radiographers were functional, that both alarm ratemeters were set to alarm at the correct value, and that hand-held survey instruments were available for conducting required surveys. After the inspection, the RSO provided the inspector with a copy of the prepared shipping papers.

During the routine, unannounced inspection conducted on July 14, 2016, the inspector observed that all of the licensee's corrective actions with regard to radiation safety equipment appeared to be effective in that there was no recurrence of the violations. Additionally, the licensee discontinued its practice of performing radiography at temporary job sites.

4 Exit Meeting Summary

On November 30, 2016, a final telephonic exit meeting was conducted with the licensee to discuss the apparent violations. The NRC also described the enforcement process and the options for the licensee moving forward, including its option to attend a predecisional enforcement conference or to provide a written response.

Supplemental Inspection Information – Health and Safety

PARTIAL LIST OF PERSONS CONTACTED

Shelly Sayer, Chief Executive Officer
Douglas Sayer, Chief Business Officer
Mathew Burke, Quality Assurance Manager
Darrin Carter, RSO
Bob Gaarsland, Radiographer

INSPECTION PROCEDURES USED

87121 Industrial Radiography Programs

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

030-36173/2015-001-01	APV	Failure to ensure that pocket dosimeters were read and the exposures recorded at the beginning and end of each shift. (10 CFR Part 34.47(b))
030-36173/2015-001-02	APV	Permitting an individual to act as a radiographer, and at all times during radiographic operations, the individual did not wear, on the trunk of the body, an operating alarm ratemeter. (10 CFR Part 34.47(a))
030-36173/2015-001-03	APV	Failure to set an alarm ratemeter to give an alarm at a dose rate of 5 mSv/hr (500 mrem/hr). (10 CFR Part 34.47(g)(2))
030-36173/2015-001-04	APV	Transport of hazardous material by highway without shipping papers prepared in accordance with 49 CFR Part 172. (10 CFR 71.5(a))

Closed

None

Discussed

None

LIST OF ACRONYMS USED

ADAMS	Agencywide Documents Access and Management System
APV	Apparent Violation
CFR	*Code of Federal Regulations*
NRC	Nuclear Regulatory Commission
PEC	Predecisional Enforcement Conference
RSO	Radiation Safety Officer