UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0199

February 20, 1996

EA 96-016

Mr. Jesús N. Osorio
[HOME ADDRESS DELETED
UNDER 10 CFR 2.290]

SUBJECT: NRC INSPECTION REPORT NO. 52-19438-01/93-02 AND
OFFICE OF INVESTIGATIONS REPORT NO. 2-93-072

Dear Mr. Osorio:

The NRC Office of Investigations (OI) recently completed an investigation of NDT Services, Inc.'s (NDTS) use of licensed materials during the performance of radiographic operations in the Commonwealth of Puerto Rico. This investigation was initiated following a December 1993 NRC inspection which reviewed the September 4, 1993, source retrieval event at the Sun Oil Refinery in Yabucoa, Puerto Rico, involving NDTS. The OI investigation sought to determine whether: (1) NDTS used unqualified persons to perform gamma radiography on September 4, 1993, at the Sun Oil Refinery; (2) whether NDTS provided falsified documentation to NRC inspectors in order to establish the qualifications of the radiographers; and (3) whether the radiographers performed radiography on September 4, 1993, without using the required alarming ratemeters.

The OI investigation concluded the following: (1) NDTS, with the knowledge and approval of the former Radiation Safety Officer (RSO) and former President, deliberately utilized radiographers untrained in NDTS operating and emergency procedures; (2) NDTS, through the actions of the former RSO, provided the NRC with documentation that falsely certified the radiographers' training; (3) the radiographers knew, or should have known, of their deficiency in complying with NRC training requirements; and (4) the radiographers failed to wear alarming ratemeters during radiography conducted on September 4, 1993.

A copy of the report of our December 1993 inspection, as well as, the synopsis of the OI Report, dated December 21, 1995, are provided as Enclosures 1 and 2, respectively.

Based on the results of the OI investigation and our earlier inspection, apparent violations of NRC requirements were identified. These findings included apparent violations for NDTS and the individuals involved in the event. Specifically, regarding your personal actions, OI concluded that you deliberately permitted unqualified radiographers to perform work at the Sun Oil Refinery on September 4, 1993, and you deliberately provided false information to the NRC. Regarding the latter, two examples were identified as follows:

1. On December 16, 1993, you knowingly provided an NRC inspector records of personnel qualifications signed by you which indicated that the qualification of two radiographers on September 3, 1993 were based on

records provided by the individuals' previous employer and experience demonstrated to you. In fact, there were no existing records to justify their qualifications as radiographers under the license at the time you signed the document and no demonstration of experience was performed prior to you signing the document.

2. On December 16, 1993, you told to an NRC inspector that you had demonstrated the safe use of the NDTS radiography equipment, and allowed radiographers to operate this equipment on September 3, 1993, when in fact you did not.

These examples constitute apparent violations of 10 CFR 30.10, Deliberate Misconduct, which is enclosed for your reference. 10 CFR 30.10 prohibits a licensee or any employee of a licensee from engaging in deliberate misconduct that causes the licensee to be in violation of any rule or regulation, in this case 10 CFR 34.31(a), "Training."

The apparent violations are being considered for escalated enforcement in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600, a copy of which is also enclosed for your reference. In addition, enforcement action is being considered against NDTS and the former President as well as the radiographers involved in the September 4, 1993 event.

Before the NRC makes its final enforcement decision, we provided you an opportunity to participate in a joint predecisional enforcement conference with NDTS and the other individuals involved in this case to discuss the apparent violations. Based on a telephone conversation between you and Mr. John Potter of my staff on February 15, 1996, you declined to attend a conference.

In accordance with the Enforcement Policy, you are afforded an opportunity for a predecisional enforcement conference prior to the NRC making a final decision regarding any escalated enforcement action. Therefore, if you are unable to attend the scheduled conference, you should promptly contact us to schedule a conference at another date and time. If you choose not to attend the conference, you should notify this office in writing of your intent within seven days of your receipt of this letter. If you should decide not to attend a conference, the NRC will proceed based on the relevant information available to us. In addition, you have the right to bring a personal representative or legal counsel. However, if you desire to bring another person, the individual should contact the NRC in advance of the conference.

Your attention is directed to Section V of the Enforcement Policy, which explains the purpose of predecisional enforcement conferences and Section VIII, which explains enforcement actions involving individuals. Note that the enforcement sanctions that could be considered include a Letter of Reprimand, a Notice of Violation and/or Order prohibiting or restricting your involvement in NRC licensed activities.

The decision to hold a conference with you does not mean that the NRC has determined that violations have occurred or that enforcement action will be taken. A conference is held to obtain information to enable the NRC to make an enforcement decision, such a common understanding of the facts, root causes, missed opportunities to identify the apparent violation sooner, corrective actions, significance of the issues and the need for lasting and effective corrective action. In addition, it is an opportunity for you to provide any information concerning your perspectives on the severity of the violations, and application of mitigation factors discussed in the Enforcement Policy, including the exercise of discretion in accordance with Section VII. NDTS representatives and the other individuals involved in this case have also been requested to attend a predecisional enforcement conference. The conferences will be closed to the public and transcribed.

In addition, please be advised that the number and characterization of the apparent violations described here may change as a result of further NRC review of this matter. You will be advised by separate correspondence of the results of our deliberations on this matter. No response regarding the apparent violations is required at this time.

At the conclusion of NRC deliberations on this matter, in accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, with your home address deleted, and its enclosures will be placed in the NRC Public Document Room.

We request that you notify us within seven days of receipt of this letter concerning your decision to attend, or not attend the scheduled conference.

Should you have any questions concerning this matter or the scheduled conference, please telephone Mr. John Potter collect at (404) 331-4503 or 5571.

Sincerely,

Bruce S. Mallett, Director
Division of Nuclear Materials Safety

Enclosures: 1. Inspection Report No. 52-19438-01/93-02
2. Investigation Report No. 2-93-072
3. 10 CFR 30.10, Deliberate Misconduct
4. NUREG-1600

(Distribution w/encls 1-3)
PUBLIC (WITHHOLD FROM PDR UNTIL CONCLUSION OF ENFORCEMENT CASE - EICS ACTION)
EJulian, SECY (WITHHOLD UNTIL DISTRIBUTED TO PDR)
BKeeling, CA (WITHHOLD UNTIL DISTRIBUTED TO PDR)
JTaylor, EDO
HThompson, DEDS
JLieberman, OE
SEbneter, RII
LChandler, OGC
JGoldberg, OGC
DCool, NMSS
Enforcement Coordinators RI, RIII, RIV
EHayden, PA (WITHHOLD UNTIL DISTRIBUTED TO PDR)
GCaputo, OI
LNorton, OIG
EJordan, AEOD
PRabideau, OC
DDandois, OC
NMamish, OE
OE:EA File (BSummers)(2)
JPotter, RII
BMallett, RII
BUryc, RII

*See previous concurrence

SEND TO PUBLIC DOCUMENT ROOM? YES NO

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DATE	02 / / 96	02 / / 96	02 / / 96	02 / / 96	02 / / 96	02 / / 96
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UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0199

FEB 04 1994

Docket No. 030-17711
License No. 52-19438-01
EA 94-029

NDT Services, Inc.
c/o Crossland Boiler Sales and Service, Inc.
ATTN: Mr. Mark Jenson
President
Scotia Bank Plaza Office #730
273 Ponce de León Avenue
Hato Rey, PR 00918

Gentlemen:

SUBJECT: (NRC INSPECTION REPORT NO. 52-19438-01/93-02)

This refers to the inspection conducted by Mr. H. Bermúdez of this office at your site on December 16-17, 1993 and the review of documents in the Region II Office on December 29-30, 1993. The inspection included a review of activities authorized for your Caguas facility. At the conclusion of the inspection, the findings were discussed with you. As a result of the findings of the inspection, a Confirmatory Action Letter was sent to you on December 30, 1993.

The inspection consisted of an examination of activities conducted under your license with respect to radiation safety and compliance with NRC regulations and the conditions of your license. It included selective examinations of procedures and representative records, interviews with personnel, and direct observations by the inspector.

The inspection findings indicate that certain of your activities appeared to be in violation of NRC requirements. Of particular concern were the conduct of licensed activities by technically unqualified individuals and the failure to perform adequate radiation surveys during the recovery of a radioactive source. The apparent violations described in the enclosed inspection report are under consideration for escalated enforcement action. Accordingly, a Notice of Violation is not being issued at this time, and a response to this letter is not required. However, 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 accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and any reply will be placed in the NRC Public Document Room.

ENCLOSURE 1

Should you have any questions concerning this letter, please contact us.

Sincerely,

/s/ Philip Stohr

D. Philip Stohr, Director
Division of Radiation Safety
and Safeguards

Enclosure:
NRC Inspection Report

cc w/encl:
Commonwealth of Puerto Rico

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0199

Report No. 52-19438-01/93-02

License No. 52-19438-01 Docket No. 030-17711

Licensee: NDT Services, Inc.
Caguas, Puerto Rico

Inspection Conducted: December 16-17 and 29-30, 1993

Inspector: _____ 2/4/94
H. Bermúdez, Sr. Radiation Specialist Date Signed

Approved By: _____ 2/4/94
C. Hosey, Chief Date Signed
Nuclear Materials Inspection Section
Nuclear Materials Safety and Safeguards Branch
Division of Radiation Safety and Safeguards

SUMMARY

Scope:

This special, announced inspection of activities conducted under NRC License No. 52-19438-01 was conducted to review the circumstances surrounding an incident involving the failure of a radiography source to retract to the safe position. Areas inspected included a review of the organization and administration of the licensed program, radiation safety training, personnel radiation protection, and transportation of radioactive materials.

Results:

Significant weaknesses were identified in the licensed program. The failures to perform required radiation safety activities and to take effective corrective action to prevent the recurrence of a previously identified violation appear to result from inadequate involvement of licensee management in the oversight of the program. Of particular concern were the conduct of licensed activities by technically unqualified individuals and the failure to perform adequate radiation surveys during the recovery of the radioactive source.

Within the scope of the inspection, the following apparent violations were identified:

- Use of licensed material by individuals who had not been trained in the provisions of 10 CFR 34.31 and as specified in the license application dated December 3, 1991.

- Failure to conduct adequate radiation surveys to assure compliance with the applicable parts of 10 CFR 20.101 that limit the radiation exposure to the whole body and the extremities.

- Failure to maintain emergency procedures to include the handling of sealed sources, methods and occasions for conducting radiation surveys, the use of personnel monitoring equipment, and minimizing the exposure of persons in the event of an accident involving the inability to retract a sealed source to its safe position.

- Failure to require that individuals disclose occupational radiation exposures received from sources of radiation controlled by other persons during the calendar quarter in which the licensee allowed access into the licensee's restricted area.

- Failure to maintain an approved quality assurance program for the transport of Type B packages, a repeat finding from an inspection conducted on June 16, 1993.

Report Details

1. Persons Contacted

T. Crossland, Owner
@J. de Arce, Industrial Hygienist, Puerto Rico Sun Oil Co.
*M. Jenson, President
*J. Osorio, Radiation Safety Officer
C. Pizarro, Radiographer
+D. Vigne, Radiation Safety Officer, National Inspection Consultants, Inc., Fort Myers, Florida

* Attended exit interview
@ By telephone on December 30, 1993
+ By telephone on December 29, 1993

2. Program Scope and Licensee Organization

License No. 52-19438-01 was originally issued on August 21, 1980, and was most recently renewed on February 26, 1992. The license allows the possession and use of cobalt-60 and iridium-192 sealed sources in industrial radiography at temporary job sites. The licensee, NDT Services, Inc., was owned by Crossland Boiler Sales & Service, Inc., a manufacturer of tanks and boilers. At the time of the inspection the licensee's Radiation Safety Officer (RSO) was the lead radiographer, supervised three additional radiographers and reported to the company president. In addition to radiography, the licensee performed other types of non-destructive inspections. Radiographic operations were a small portion of the licensee's activities.

3. Sequence of Events Surrounding the Incident

Through review of records, a re-enactment of the incident and interviews with licensee representatives and other individuals related to the incident the inspector determined the following:

The licensee was asked by a refinery subcontractor to provide radiography services during a refinery outage which required more manpower than the licensee had available. The licensee committed to provide the services relying on another radiography company from the mainland to provide the needed manpower. The licensee's president contacted a colleague at the other company and requested the company supplied two individuals to cover the job. Believing that the licensee was going to train the two individuals per the licensee's specific license requirements and properly qualify them as radiographers, the company supplied the two individuals. The two supplied individuals were not qualified as radiographers or radiographer's assistants per the supplying company's license and approved training program, nor were they authorized to conduct licensed

activities under the company's license. Believing that the individuals were qualified radiographers, on September 3, 1993, the licensee's RSO gave the individuals a demonstration on how to use the radiography equipment, allowed them to handle the equipment, and qualified them as radiographers with no further training or examinations.

On the morning of September 4, 1993, the individuals arrived at the refinery and began setting up the equipment at the designated work location. While setting up the equipment, one of the individuals failed to connect the "pig tail" (to which the radioactive source is attached) to the cable used to expose and retract the source (the drive cable); the individual only connected the drive cable conduit (through which the drive cable travels) to the exposure device. During the first exposure, the drive cable pushed the 75-curie iridium-192 source to the end of the source guide tube, exposing the source, but was unable to retract the source because the source was not connected to the drive cable. After several unsuccessful attempts to retract the source to the shielded position, the individuals contacted a licensee radiographer who was at a different location in the refinery, who contacted the licensee's president, who in turn contacted the RSO. The radiographer and refinery safety personnel extended the restricted area boundary lines to where radiation levels measured two millirems per hour and ensured that all personnel within the newly defined restricted area had been evacuated. Licensee and refinery safety personnel maintained control of the restricted area for the duration of the event.

Due to the remote location of the refinery relative to the location of the RSO when the RSO was notified of the problem, it took him approximately three hours to arrive at the site with the necessary equipment. The RSO noted that, as he made his first approach to the area where the source was located, radiation levels were such that they caused his survey instrument reading to go off-scale and caused his alarming ratemeter to alarm. The RSO did not evaluate the extent of radiation hazards that were present prior to attempting the source recovery even though he knew that radiation levels were higher than what he was able to measure. In a series of approximately seven entries to the immediate vicinity of the source, and with the use of a remote-handling tool on one occasion, the RSO freed the source guide tube containing the source, forced the source to the opposite end of the guide tube exposing the source "pig tail," connected the "pig tail" to the drive cable and retracted the source to the shielded position. The RSO was wearing his film badge on his shirt pocket and, during several steps of the recovery, the film badge was shielded by other parts of his body which were closer to the source.

The RSO did not evaluate the exposure rate at the "pig tail" prior to connecting the "pig tail" to the drive cable, nor did he evaluate the exposure his hands received while making the connection. Also, the RSO did not check his pocket dosimeter until the end of the source recovery, when he noted it was off-scale. The licensee immediately sent the film badges of all personnel involved in the incident for processing by its dosimetry vendor.

4. Consequences

The radiation exposures of the licensee individuals not directly involved in the source recovery were well within regulatory requirements. The highest recorded exposure of the licensee individuals was 190 millirems. The RSO's recorded exposure was also 190 millirems. However, based on a re-enactment of the incident and discussions with the RSO, the inspector determined that unmonitored parts of the RSO's whole body received exposures of up to 500 millirems. The estimated highest exposure of the RSO during the incident added to other occupational exposures received by the RSO during the third quarter of 1993 was 550 millirems, which was below the regulatory limit of 1250 millirems per quarter. Based on discussions with licensee representatives and personnel from the refinery's health and safety staff who responded to the event, the inspector determined that no refinery personnel or other members of the public received any measurable radiation exposure as a result of the incident.

5. Licensee Response to the Event and Corrective Actions

As noted above, after realizing that the source was not retracting to the shielded position, the individuals warned people in their immediate area and notified a licensee radiographer who was in another area of the refinery. The licensee radiographer unsuccessfully attempted to retract the source and notified the subcontractor, who notified refinery safety personnel of the problem. The radiographer also notified licensee management. The licensee's president notified the RSO, who gathered the necessary equipment and responded to the event. Although the RSO reacted promptly to the event, for reasons beyond his control he did not arrive at the refinery until three hours after the incident began. During that time, refinery safety personnel assumed the lead for extending the boundaries of the restricted area and controlling the area. The use of remote-handling tools during the source retrieval was a major contributor to the relatively low radiation exposure received by the RSO. The two individuals involved in the incident were instructed to return to the mainland. The licensee submitted the required incident report to the NRC within the required time frame.

6. Regulatory Issues Associated With the Incident

Condition 12 of License No. 52-19438-01 requires that licensed material be used by, or under the supervision and in the physical presence of, individuals who have been trained as specified in the application dated December 3, 1991 and the provisions of 10 CFR 34.31. 10 CFR 34.31(a) requires, in part, that the licensee not permit any individual to act as a radiographer until such individual: has been instructed in the subjects outlined in Appendix A of 10 CFR Part 34; has received copies of and instructions in NRC regulations contained in 10 CFR Part 34 and in the applicable sections of 10 CFR Parts 19 and 20, NRC license under which the radiographer will perform radiography and the licensee's operating and emergency procedures; and has demonstrated understanding of the instructions in this paragraph by successful completion of a written test on the subjects covered. The failure to train two individuals as specified in the licensee's approved training program submitted in the application dated December 3, 1991, and allowing the individuals to act as radiographers using licensed material without receiving the training specified in 10 CFR 34.31 was identified as an apparent violation of Condition 12 of License No. 52-19438-01.

10 CFR 20.201(b) requires that the licensee make such surveys as may be necessary to comply with the requirements of Part 20 and which may be reasonable under the circumstances to evaluate the extent of radiation hazards which may be present. As defined in 10 CFR 20.201(a), "survey" means an evaluation of the radiation hazards incident to the production, use, release, disposal or presence of radioactive materials or other sources of radiation under a specific set of conditions. As discussed in Section 3 above, the licensee did not make surveys to assure compliance with the applicable parts of 10 CFR 20.101 that limit the radiation exposure to the whole body and the extremities. Specifically, (1) During a source retrieval event on September 4, 1993, the licensee's Radiation Safety Officer (RSO) knew that his survey instrument indicated that radiation levels were above the instrument's range and his alarm ratemeter, preset at 500 millirems per hour, was alarming during his first approach to the event area and failed to evaluate the radiation levels to which his whole body and extremities were to be exposed; (2) As of December 17, 1993, the licensee had not evaluated the exposure to the extremities of the RSO as a result of the source retrieval event; (3) As of December 17, 1993, the licensee's evaluation of the RSO's exposure to the whole body was inadequate in that the film badge used to assess the RSO's exposure was worn in such a way that it was shielded by parts of the body during the retrieval event, and the RSO

failed to wear the film badge in that portion of the whole body likely to receive the highest exposure. These three issues were identified as three examples of an apparent violation of 10 CFR 20.201(b).

10 CFR 34.32 requires, in part, that the licensee retain a copy of current operating and emergency procedures which include instructions in, among others, the handling of sealed sources such that no person is likely to be exposed to radiation doses in excess of the limits established in 10 CFR 20, methods and occasions for conducting radiation surveys, the use of personnel monitoring equipment, and minimizing exposure of persons in the event of an accident. While reviewing the implementation of the licensee's program as it applied to the incident the inspector determined that, as of December 17, 1993, the licensee's emergency procedures did not include instructions in the handling of sealed sources, methods and occasions for conducting radiation surveys, the use of personnel monitoring equipment and minimizing exposure of persons in the event of an accident involving the inability to retrieve a sealed source to its safe position. The failure to have written procedures on how to perform a source retrieval addressing the above areas was identified as an apparent violation of 10 CFR 34.32.

7. Other Regulatory Issues

10 CFR 20.102(a) requires, in part, that the licensee require any individual, prior to first entry into the licensee's restricted area during each employment or work assignment under such circumstances that the individual is likely to receive in any period of one calendar quarter an occupational dose in excess 25 percent of the applicable standards specified in 10 CFR 20.101(a), to disclose a written, signed statement indicating either: (1) That the individual had no prior occupational dose during the current calendar quarter, or (2) the nature and amount of any occupational dose which the individual may have received during that specifically identified current calendar quarter from sources of radiation possessed or controlled by other persons. While reviewing the incident, the inspector determined that, on September 4, 1993, the licensee allowed the two individuals involved in the event to perform radiographic operations under circumstances that the individuals were likely to receive occupational doses in excess of 25 percent of the applicable standards specified in 10 CFR 20.101(a) in a calendar quarter without requiring that the individuals disclose the required written statement indicating the nature of any occupational exposures received during the quarter. The failure to require the individuals to disclose the written statement specified above was identified as an apparent violation of 10 CFR 20.102(a).

10 CFR 71.12 states, in part, that a general license to transport licensed material, or to deliver licensed material to a carrier for transport, applies only to a licensee who has a quality assurance program approved by the Commission as satisfying the provisions of Subpart H of 10 CFR Part 71. While reviewing the licensee's program the inspector determined that, as of December 17, 1993, the licensee routinely transported licensed material under the general license pursuant to 10 CFR 71.12, and the licensee did not have a quality assurance program approved by the Commission. Specifically, the licensee's quality assurance program expired in 1989. The licensee was cited for failing to meet the stated requirement during an NRC inspection conducted on June 16, 1993. Licensee management indicated that the failure to submit for NRC approval a quality assurance program for their transportation packages satisfying the provisions on Subpart H of 10 CFR 71 was due to a misunderstanding of the requirement, and that they will expedite the submittal of the required program for NRC approval. The failure to maintain an approved quality assurance program to satisfy the provisions of Subpart H of 10 CFR 71 was identified as an apparent repeat violation of 10 CFR 71.12.

8. Exit Interview

The inspection scope and results were summarized in an exit interview with those individuals identified in Section 1 of this report. The inspector reviewed the program areas inspected and discussed in detail the inspection findings. The NRC's enforcement policy was reviewed with licensee representatives. The inspector reminded licensee management that the NRC expects licensee management to be ultimately responsible for all activities conducted under the NRC license. Licensee management acknowledged the NRC's concerns regarding the need for better oversight of licensed activities. Licensee representatives did not provide dissenting comments relative to the apparent violations discussed in this report. Proprietary information is not contained in this report.

In addition, the results of this inspection were discussed in a telephone conversation between Mr. Mark Jenson of NDT Services, Inc. and Mr. Douglas Collins of this office on December 30, 1993. The initial corrective actions to the inspection findings, discussed during this call, were documented in a Confirmatory Action Letter dated December 30, 1993.

SYNOPSIS

The U.S. Nuclear Regulatory Commission (NRC), Office of Investigations (OI), Region II Field Office, initiated this investigation on December 30, 1993. The investigation examines whether NDT Services, Inc. (NDTS), Caguas, Puerto Rico, utilized unqualified personnel to perform gamma radiography on September 4, 1993, at the Sun Oil refinery, Yabucoa, Puerto Rico. The investigation further addresses whether NDTS provided NRC inspectors with falsified documentation in an effort to establish the qualifications of the radiographers and whether radiographers performed radiography without the protection of alarm ratemeters. These issues surfaced as a result of a source retrieval event which resulted in the evacuation of the Sun Oil refinery. The source retrieval event additionally brought to light a number of other concerns which the NRC inspection staff addressed independently.

Based on evidence developed and reviewed during this investigation OI determined NDTS deliberately utilized radiographers, that lacked training in NDTS' operating and emergency procedures, to perform gamma radiography. OI further determined NDTS, through actions of the radiation safety officer, provided the NRC with documentation which falsely certified the radiographers' training. Additionally, OI determined the subject radiographers performed gamma radiography and knew or should have known the NRC training requirements and their deficiency in meeting those requirements. OI further determined the radiographers performed radiography without wearing alarm ratemeters.

58 FR 52406

(d) Actions taken by an employer, or others, which adversely affect an employee may be predicated upon nondiscriminatory grounds. The prohibition applies when the adverse action occurs because the employee has engaged in protected activities. An employee's engagement in protected activities does not automatically render him or her immune from discharge or discipline for legitimate reasons or from adverse action dictated by nonprohibited considerations.

(e)(1) Each specific licensee, each applicant for a specific license, and each general licensee subject to part 19 shall prominently post the revision of NRC Form 3, "Notice to Employees," referenced in 10 CFR 19.11(c).

60 FR 24549

(2) The posting of NRC Form 3 must be at locations sufficient to permit employees protected by this section to observe a copy on the way to or from their place of work. Premises must be posted not later than 30 days after an application is docketed and remain posted while the application is pending before the Commission, during the term of the license, and for 30 days following license termination.

Note: Copies of NRC Form 3 may be obtained by writing to the Regional Administrator of the appropriate U.S. Nuclear Regulatory Commission Regional Office listed in appendix D to part 20 of this chapter or by contacting the NRC Information and Records Management Branch (telephone no. (301) 415-7230).

58 FR 52406

(f) No agreement affecting the compensation, terms, conditions, or privileges of employment, including an agreement to settle a complaint filed by an employee with the Department of Labor pursuant to section 211 of the Energy Reorganization Act of 1974, as amended, may contain any provision which would prohibit, restrict, or otherwise discourage an employee from participating in protected activity as defined in paragraph (a)(1) of this section including, but not limited to, providing information to the NRC or to his or her employer on potential violations or other matters within NRC's regulatory responsibilities.

49 FR 19623

§ 30.8 Information collection requirements: OMB approval.

(a) The Nuclear Regulatory Commission has submitted the information collection requirements contained in this part to the Office of Management and Budget (OMB) for approval as required by the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq). OMB has approved the information collection requirements contained in this part under control number 3150-0017.

59 FR 61767

(b) The approved information collection requirements contained in this part appear in §§ 30.9, 30.11, 30.15, 30.19, 30.20, 30.32, 30.34, 30.35, 30.36, 30.37, 30.38, 30.41, 30.50, 30.51, 30.55, and Appendix A.

(c) This part contains information collection requirements in addition to those approved under the control number specified in paragraph (a) of this section. These information collection requirements and the control numbers under which they are approved are as follows:

(1) In §§ 30.32, 30.37, and 30.38, NRC Form 313 is approved under control number 3150–0120.

(2) In § 30.36, NRC Form 314 is approved under control number 3150–0028.

52 FR 49362

§ 30.9 Completeness and accuracy of information.

(a) Information provided to the Commission by an applicant for a license or by a licensee or information required by statute or by the Commission's regulations, orders, or license conditions to be maintained by the applicant or the licensee shall be complete and accurate in all material respects.

52 FR 49362

(b) Each applicant or licensee shall notify the Commission of information identified by the applicant or licensee as having for the regulated activity a significant implication for public health and safety or common defense and security. An applicant or licensee violates this paragraph only if the applicant or licensee fails to notify the Commission of information that the applicant or licensee has identified as having a significant implication for public health and safety or common defense and security. Notification shall be provided to the Administrator of the appropriate Regional Office within two working days of identifying the information. This requirement is not applicable to information which is already required to be provided to the Commission by other reporting or updating requirements.

§ 30.10 Deliberate misconduct.

56 FR 40664

(a) Any licensee or any employee of a licensee; and any contractor (including a supplier or consultant), subcontractor, or any employee of a contractor or subcontractor, of any licensee, who knowingly provides to any licensee, contractor, or subcontractor, components, equipment, materials, or other goods or services, that relate to a licensee's activities subject to this part; may not:

(1) Engage in deliberate misconduct that causes or, but for detection, would have caused, a licensee to be in violation of any rule, regulation, or order, or any term, condition, or limitation of any license, issued by the Commission, or

(2) Deliberately submit to the NRC, a licensee, or a licensee's contractor or subcontractor, information that the person submitting the information knows to be incomplete or inaccurate in some respect material to the NRC.

(b) A person who violates paragraph (a)(1) or (a)(2) of this section may be subject to enforcement action in accordance with the procedures in 10 CFR part 2, subpart B.

(c) For purposes of paragraph (a)(1) of this section, deliberate misconduct by a person means an intentional act or omission that the person knows:

(1) Would cause a licensee to be in violation of any rule, regulation, or order, or any term, condition, or limitation, of any license issued by the Commission, or

(2) Constitutes a violation of a requirement, procedure, instruction, contract, purchase order or policy of a licensee, contractor, or subcontractor.

ENCLOSURE 3