

VOID SHEET

TO: License Fee Management Branch

FROM: RIII - COLLEEN CASEY

SUBJECT: VOIDED APPLICATION

Control Number: 301879
Applicant: Mercy Health System - Western Ohio
License Number: 34-00852-02
Docket Number: 030-02659
Date Voided: 10/17/96
Reason for Void: Licenses intended to submit

a notification per 70 CFR 35.14 only - no fee. They withdrew
8/20/96 in favor of notification letter replacement.

Colleen C. Casey
Signature

10/17/96
Date

Attachment:
Official Record Copy of
Voided Action

FOR LFMB USE ONLY

- ☐ Refund Authorized and processed
☒ No Refund Due
☐ Fee Exempt or Fee Not Required

Comments: _____

Log completed ☒

Processed by: SAC 1/23/97

ML
30
SD

BETWEEN:

License Fee Management Branch, ARM
and
Regional Licensing Sections

(FOR LFMS USE)
INFORMATION FROM LTS

Program Code: 02120
Status Code: 0
Fee Category: 7C 2B
Exp. Date: 20040831
Fee Comments:
Decon Fin Assur Req'd: N

LICENSE FEE TRANSMITTAL

A. REGION

1. APPLICATION ATTACHED

Applicant/Licensee: MERCY HEALTH SYSTEM-WESTERN OHIO
Received Date: 960926
Docket No: 3002659
Control No.: 301879
License No.: 34-00852-02
Action Type: Amendment

*Returned to RTH
1/13/97, for voiding
SC*

2. FEE ATTACHED

Amount: 0
Check No.: 0

3. COMMENTS

Signed D. Hersey
Date 9-27-96

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

1. Fee Category and Amount: 7C 2B

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

Amendment ✓
Renewal _____
License _____

3. OTHER _____

Signed _____
Date _____

1996 OCT -3 AM 11:09

JAN 16 1997

Log	<u>OCT 1 1997</u>
Remitter	_____
Check No.	_____
Amount	_____
Fee Category	<u>7C 2B</u>
Type of Fee	<u>AMD</u>
Date Check Rec'd	_____
Date Completed	_____
By	_____

September 19, 1996

34-00852-02

U.S. Nuclear Regulatory Commission
Region III - Materials Licensing Section
801 Warrenville Road
Lisle, Illinois 60532-4351

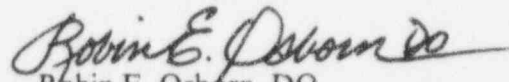
REF: Mubin I. Syed, M.D.

Dear Sir or Madam:

Request that Dr. Mubin I. Syed be added to the hospital license as an authorized user for 35.100, 35.200 and 35.300. Dr. Syed has experience with 5 hyperthyroid and 2 carcinoma treatments. I plan to proctor him on 5 additional hyperthyroid treatments.

If you need further information, please feel free to contact me.

Very truly yours,


Robin E. Osborn, DO
Chief Radiologist

RFO:jac

RECEIVED
SEP 23 1996
REGION III

Pm: 9-20-96

301879

August 20, 1996

U.S. Nuclear Regulatory Commission
Region III - Materials Licensing Section
801 Warrenville Road
Lisle, IL 60532-4351

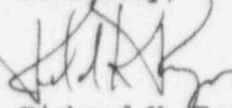
Reference: Mubin Syed, M.D.

Dear Sir or Madame:

This letter will confirm that Mubin Syed, M.D. was appointed to the Active Staff of Mercy Medical Center on July 16, 1996 with privileges in the Department of Medical Services, Clinical Section of Radiology.

Dr. Syed is a member in good standing, having met all requirements for maintaining privileges, including professional, moral, ethical and physical requirements.

Sincerely,



Richard K. Rogers
Senior Vice President

g/5/credltr/RKR:lb

EXHIBIT 2
SUPPLEMENT A

SUPPLEMENT		U.S. NUCLEAR REGULATORY COMMISSION	
TRAINING AND EXPERIENCE AUTHORIZED USER OR RADIATION SAFETY OFFICER			
1. NAME OF PROPOSED AUTHORIZED USER OR RADIATION SAFETY OFFICER		2. FOR PHYSICIANS, STATE OR TERRITORY WHERE LICENSED	
Mubin I. Syed		IN, Ohio	
3. CERTIFICATION			
SPECIALTY BOARD A	CATEGORY B	MONTH AND YEAR CERTIFIED C	
Diagnostic Radiology (American Board of Radiology)		11/94	
4. TRAINING RECEIVED IN BASIC RADIOISOTOPE HANDLING TECHNIQUES			
FIELD OF TRAINING A	LOCATION AND DATE(S) OF TRAINING B	TYPE AND LENGTH OF TRAINING	
		CLOCK HOURS IN LECTURE OR LABORATORY	CLOCK HOURS OF SUPERVISED ON-THE-JOB EXPERIENCE
a. RADIATION PHYSICS AND INSTRUMENTATION	1991-1992 Indiana University Medical Center Radiology Classroom B - Fesler Hall	127	22.5
b. RADIATION PROTECTION	1991 Indiana University Medical Center Radiology Classroom B - Fesler Hall	20	
c. MATHEMATICS PERTAINING TO THE USE AND MEASUREMENT OF RADIOACTIVITY	1992 Indiana University Medical Center Radiology Classroom B - Fesler Hall	16	
d. RADIATION BIOLOGY	1992 Indiana University Medical Center Radiology Classroom B - Fesler Hall	20	
e. RADIOPHARMACEUTICAL CHEMISTRY	1992 Indiana University Medical Center Radiology Classroom B - Fesler Hall	32	15
5. EXPERIENCE WITH RADIATION. (Actual use of Radioisotopes or Equivalent Experience)			
ISOTOPE	mCi USED AT ONE TIME	LOCATION	CLOCK HOURS
Tc99m	30	Indiana University Medical Center VAMC, Indianapolis	500
Xe133	28		
TL201	3.0		
I131	120		
Oa-67	5		
I-123	20uci uptake 400uci scan		
IN111	0.6mCi		
			Clinical and Laboratory

**EXHIBIT 3
SUPPLEMENT B**

SUPPLEMENT		U. S. NUCLEAR REGULATORY COMMISSION	
PRECEPTOR STATEMENT			
<i>Supplement B must be completed by the applicant physician's preceptor. If more than one preceptor is necessary to document experience, obtain a separate statement from each.</i>			
1. PROPOSED PHYSICIAN USER'S NAME AND ADDRESS <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> FULL NAME Mubin I. Syed </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> STREET ADDRESS 2838 Wellsford Lane Springfield, OH 45503 </div> <div style="display: flex; justify-content: space-between; border-top: 1px solid black; padding-top: 2px;"> CITY STATE ZIP CODE </div>		KEY TO COLUMN C PERSONAL PARTICIPATION SHOULD CONSIST OF: 1. Supervised examination of patients to determine the suitability for radioisotope diagnosis and/or treatment and recommendation for prescribed dosage. 2. Collaboration in dose calibration and actual administration of dose to the patient including calculation of the radiation dose, related measurements and plotting of data. 3. Adequate period of training to enable physician to manage radioactive patients and follow patients through diagnosis and/or course of treatment.	
2. CLINICAL TRAINING AND EXPERIENCE OF ABOVE NAMED PHYSICIAN			
ISOTOPE <small>A</small>	CONDITIONS DIAGNOSED OR TREATED <small>B</small>	NUMBER OF CASES INVOLVED PERSONAL PARTICIPATION <small>C</small>	COMMENTS <small>(Additional information or comments may be submitted in duplicate or separate sheets.) D</small>
	Thyroid scan	22	
	Thyroid uptake	16	
	Lung perfusion scan	61	
	Xenon ventilation study	59	
	Aerosol ventilation scan	0	
	Renal flow scan	212	
	Brain scan	16	
	Liver/spleen scan	8	
	Bone scan	317	
	Gastroesophageal study	160	
	LeVeen shunt study	0	
	Cystogram	20	
	Decryocystogram	0	
	Cardiac perfusion scan	144	
	Cardiac stress ventriculogram		
Cardiac rest ventriculogram	101		
Gallium scan	8		

EXHIBIT 3 (Continued)

PROPOSED PHYSICIAN USER

Mubin I. Syed

PRECEPTOR STATEMENT (Continued)

2. CLINICAL TRAINING AND EXPERIENCE OF ABOVE NAMED PHYSICIAN (Continued)

ISOTOPE A	CONDITIONS DIAGNOSED OR TREATED B	NUMBER OF CASES INVOLVING PERSONAL PARTICIPATION C	COMMENTS (Additional information or comments may be submitted in duplicate on separate sheets.) D
P-32 (Schröder)	TREATMENT OF POLYCYTHEMIA VERA, LEUKEMIA, AND BONE METASTASES		
P-32 (Celbide)	INTRACAVITARY TREATMENT		
I-131	TREATMENT OF THYROID CARCINOMA	2	
	TREATMENT OF HYPERTHYROIDISM	5	
Au-198	INTRACAVITARY TREATMENT		
Co-60 or Co-137	INTERSTITIAL TREATMENT		
	INTRACAVITARY TREATMENT		
I-125 or Ir-192	INTERSTITIAL TREATMENT		
Co-60 or Co-137	TELE THERAPY TREATMENT		
Sr-90	TREATMENT OF EYE DISEASE		
	RADIOPHARMACEUTICAL PREPARATION		
Mo-99/ Tc-99m	GENERATOR	5	
Sr-113/ In-113m	GENERATOR		
Tc-99m	REAGENT KITS	10	
Other			

3. DATES AND TOTAL NUMBER OF HOURS RECEIVED IN CLINICAL RADIOISOTOPE TRAINING

LOCATION	DATES	CLOCK HOURS OF EXPERIENCE
Indiana University Medical Center	1990 to 1992	Total 500 hours
VAMC, Indianapolis		
Wishard Hospital, Indianapolis		

4. THE TRAINING AND EXPERIENCE INDICATED ABOVE WAS OBTAINED UNDER THE SUPERVISION OF:

a. NAME OF SUPERVISOR

Robert Burt, M.D.

b. NAME OF INSTITUTION

Indiana University Medical Center

c. MAILING ADDRESS

550 N. University Blvd. UH0663

d. CITY

Indianapolis, IN 46202

e. MATERIALS LICENSE NUMBER(S)

f. PRECEPTOR'S SIGNATURE

Robert Burt M.D.

g. PRECEPTOR'S NAME (Please type or print)

Robert Burt, M.D.

h. DATE

7/24/98

DATE: 9-25-96

CORRESPONDENCE CLARIFICATION SHEET

REVIEWER: John Madera
LICENSEE: Mercy MED CTR.
LICENSE NUMBER: 34-00852-03

The following correspondence has been received from the above licensee and it is not clear what action(s) is(are) required: Please review this correspondence and indicate which of the following applies, and please return to Debbie Hersey, as soon as possible.

☐ Additional Information to Control No. _____.
Process in as a new action, additional information, and no fee required.

☐ Process as new licensing action. Review has already been started on Control No. _____ and this information cannot be combined with current in-house action.

☐ Can be combined with Control No. _____. Review has not been started.

☒ Appears to be a(n) Amendment - process.

☐ Appears to be information for the license file - file it.

☐ Licensee is adding Nuclear Pharmacists.
Amendment is necessary _____. Amendment is not necessary _____.
(Information for license file)

☒ Licensee is adding authorized users.
A check is included _____. No check is included _____.
Amendment is necessary _____. Amendment is not necessary _____.
(Information for the license file)

☐ Other: _____

Thank You For Your Help!!!

02/02/95

LICENSE FEE REQUIREMENTS

LICENSE FEE AND DEBT COLLECTION BRANCH
DIVISION OF ACCOUNTING AND FINANCE
OFFICE OF THE CONTROLLER
U.S. NUCLEAR REGULATORY COMMISSION
WASHINGTON, DC 20555-0001MERCY MEDICAL CENTER
ATTN: ROBIN E. OSBORN, D.O.
CHIEF RADIOLOGIST
1343 N. FOUNTAIN BOULEVARD
SPRINGFIELD, OHIO 45501-1380

TYPE OF ACTION

- ☐ NEW LICENSE
☐ RENEWAL OF LICENSE
☒ AMENDMENT TO LICENSE

REQUESTED DATE

9-19-96

LICENSE NUMBER

34-00852-02

CONTROL NUMBER

301879

I. APPLICATION FEE DUE

Your request for a licensing action is subject to the fee(s) in the category(ies) noted below in accordance with Section 170.31 of the enclosed Federal Register notice. Payment of the fee is required prior to the issuance of the license, renewal, or amendment.

FEE CATEGORY	APPLICATION	RENEWAL	AMENDMENT
7C	\$	\$	\$ 440.00
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$

FEE(s) DUE	\$	440.00
PAYMENT RECEIVED	\$	0.00
AMOUNT DUE	\$	440.00

- ☒ Your request was received without the prescribed application fee.
- ☐ We received your Check No. _____ in the amount of \$ _____. Payment of the additional fee noted above is required.
- ☐ Your request will increase the scope of your license program. Therefore, your request is subject to the application fee(s) noted above. Refer to Section 170.31 and Footnote 1(d)(2).
- ☐ Your license expired prior to the receipt of your application for renewal. Therefore, your request is subject to the application fee(s) noted above. Refer to Section 170.31 and Footnote 1(a).

MAKE PAYMENT OF THE FEE(S) TO THE U.S. NUCLEAR REGULATORY COMMISSION AND MAIL THE PAYMENT TO THE ADDRESS LISTED AT THE TOP OF THIS FORM. IF WE DO NOT RECEIVE A REPLY FROM YOU WITHIN 30 CALENDAR DAYS FROM THE DATE LISTED BELOW, WE SHALL ASSUME THAT YOU DO NOT WISH TO PURSUE YOUR APPLICATION AND WILL VOID THIS ACTION.

SIGNATURE OF LICENSE FEE ANALYST

LFDCB

LFDCB

SHIRLEY BRUTCHFIELD

10/7/96

II. FEE NOT REQUIRED

- ☐ Enclosed is Check No. _____ which accompanied your request. The fee is not required because:
- ☐ We received your Check No. _____ in payment of the fee.
- ☐ The Licensing staff has informed us that your request is to be considered as a continuation of your request dated _____, Control No. _____.
- ☐ Your request was combined, prior to review, with your _____ request, Control No. _____.

III. CHECK RETURNED

- ☐ Enclosed is Check No. _____ which was returned to us by the bank for:
- ☐ INSUFFICIENT FUNDS
- ☐ ACCOUNT CLOSED
- ☐ OTHER

MAIL THE REPLACEMENT CHECK TO THE ADDRESS LISTED AT THE TOP OF THIS FORM AND REFERENCE THE ABOVE CONTROL NUMBER.

IV. LICENSE ISSUED WITHOUT THE REQUIRED FEE

- ☐ License No. _____, Amendment No. _____, issued on _____ was issued without the required fee being collected. The fee required is noted in Section I of this form.
- ☐ The scope of your licensed program was increased. Therefore, your request is subject to the application fee(s) noted in Section I of this form. Refer to Section 170.31 and Footnote 1(d)(2).
- ☐ Because of the urgency of your request, the license was issued without remittance of the prescribed fee noted in Section I of this form.

Distribution:

Pending Fee File

LFARB R/F (2)

OC/DAE/R/F
OC/DAE/SF(LF-3.2.7)
Region 3

DATE

10/7/96



1343 N. Fountain Boulevard Springfield, Ohio 45501-1380 513/390-5000 FAX: 513/390-5507

CONVERSATION RECORD

TIME

10:05am

DATE

9/27/96

TYPE

☐ VISIT

☐ CONFERENCE

☒ TELEPHONE

☒ INCOMING

☐ OUTGOING

ROUTING

NAME/SYMBOL

INT

Location of Visit/Conference:

NAME OF PERSON(S) CONTACTED OR IN CONTACT WITH YOU

CHIEF TECH.

RAD. THERAPY

ORGANIZATION (Office, dept., bureau, etc.)

MERCY MEDICAL CENTER

TELEPHONE NO.

513-390-5026

SUBJECT

L/A 34-00852-02 C/N 301879

Deficiency call - preliminary Htd 9/19/96

SUMMARY

Ms. Bonner called because she received our acknowledgment letter requesting an amend fee check. She (& her RSO & her consultant) thought they were sending us a Part 35.14 notification for Dr. Syed. I explained that the 9/19/96 ltr does not qualify for the notification because of the Preceptor form attached & Dr. Syed's request for 35.300 material (not covered by Dx Radiology ABR certification). Ms. Bonner et al were not clear on this rule/reg (10CFR 35.13 & 35.14). She has 2 choices: (1) Drop the request for 35.300 material in a letter to us because we can't approve it anyway & don't amend now, tell us it's a notification; or (2) send us the check & will pay Dr. Syed to license for 35.100 + 35.200 + we'll deficiency the 35.300 until later date after Dr. Syed completes required hypothyroid & CA cases. Then, we'll amend for fee, limited to Dr. Syed's cost for 35.300 material. Ms. Bonner will think about this, check with her mgmt & call me about which option they want.

15 day response

SIGNATURE

Kolleen C. Casey

TITLE

NMCLB Reviewer

DATE

9/27/96

CONVERSATION RECORD