

# Irvington General Hospital

November 25, 1985

John E. Glenn, Ph. D  
Chief, Nuclear Materials Safety Section B  
Division of Radiation Safety & Safeguards  
U.S. Nuclear Regulatory Commission  
631 Park Avenue  
King of Prussia, PA 19406

RE: Inspection Report  
#030-02508/85-01  
License #29-07989-02

Dear Dr. Glenn:

This letter is in response to your safety inspection conducted on September 13, 1983 and your letter dated October 31, 1985.

A1. Effective immediately, for all radioactive materials to be delivered to a carrier for transport shall be shipped according to 49CFR 172.03, (d) (iii) (IV) and (V), to include all the required information. Each shipment record shall include the activity contained in each package in terms of curies, millicuries, or microcuries, the category of label applied to each package, and the transport index on its shipping papers. Monthly checks of the shipping papers shall be done by our consultant physicist for report to the radiation safety officer and/or the radiology manager.

B1. As required, the radiation safety/medical isotopes committee shall meet at least quarterly and as often as necessary and required to conduct its necessary duties and functions. As of March 15, 1985, this committee has met the required number of times and will continue to do so.

B2. Effective since March 15, 1985, the dose calibrator has been checked daily for instrument constancy and verification will continue to be made to determine whether the variation is greater than  $\pm 5\%$  from the predicted activity. Any variation exceeding  $\pm 5\%$  shall be grounds for confirming the need for repair and/or adjustment of the dose calibrator. Upon verification through the additional constancy checks for the dose calibrator, adjustments and/or repair of the dose calibrator will be made. These additional constancy checks will provide better information on determining

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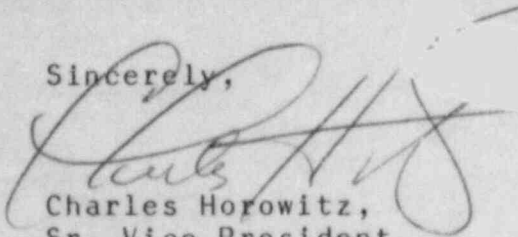
possibly if environmental factors such as heat, humidity, line voltage variations or grounding, and/or operator error are causing the variations to occur. On the same day when the excessive variation is discovered and the additional constancy checks for the dose calibrator is completed, the chief nuclear medicine technologist shall note on the dose calibrator constancy records what actions were taken to correct the noted excessive variation.

In addition, regular but unscheduled operational audits shall be conducted by our consulting physicist and the results of these audits will be forwarded to the Radiation Safety Officer, Radiation Safety Committee and the Radiation Manager so that corrective action can be taken immediately, if required.

B3. Effective immediately, the dose calibrator shall be checked at least annually for instrument accuracy using Cobalt 57, Cesium 137, and Cobalt 60. This procedure will remain in effect until our by-product license is either amended or renewed in the near future. We have advised our consultant physicist to include as his responsibility the quarterly check of the instrument accuracy and to record the results.

Please feel free to contact me should you have any questions concerning our response to your inspection findings.

Sincerely,



Charles Horowitz,  
Sr. Vice President

CH:is

cc: Jeffrey Blonstein, MD, Radiation Safety Officer  
Richard W. Conner, Technology Director Imaging Services