ADVISORY
COUNCIL ON
RADIATION PROTECTION

CERTIFIED
TRANSCRIPT

Bureau of Radiation Control

Hampton Inn & Suites

Tampa Airport Avion Park Westshore

Tampa, Florida 33607

Thursday, December 2, 2021

10:01 a.m. - 2:41 p.m

Reported by
Rita G. Meyer, RDR, CRR, CRC
Realtime Reporter and Notary Public
State of Florida at Large

ADVISORY COUNCIL MEMBERS PRESENT:

Randy Schenkman, M.D., Retired (Chairman)
Mark S. Seddon, M.P., DABR, DABMP (Vice-Chairman)
Rebecca McFadden, RT(R)
Nicholas Plaxton, M.D.
Adam Weaver, MS, CHP
Mark Wroblewski
Chantel Corbett, AS, CNMT, RT (N), RSO
George Gilbride, R.R.A, R.T.(R)(CT)(ARRT)
William "Bill" Atherton, DC, DACBR, CCSP
Joseph Danek, CHP

FLORIDA DEPARTMENT OF HEALTH STAFF

Cynthia Becker, Bureau of Radiation Control
James Futch, Bureau of Radiation Control
Clark Eldredge, Bureau of Radiation Control
Douglass Cooke, Bureau of Radiation Control
Giovanna Manning, Bureau of Radiation Control
John Williamson, Bureau of Radiation Control

SkinCure Oncology Presenters:

Dr. Lio Yu, Radiation Oncologist
Steven Scott, Chief Operating Officer
Joshua Swindle, Director of Practice Operations

AGENDA

MORNING SESSION

AFTERNOON SESSION

DR. RANDY SCHENKMAN: Welcome everybody to our real live meeting for a change. A good change, we hope. So everybody can get to know each other, why don't we start with everybody introducing themselves. Do we want to start with you?

STEVEN SCOTT: Do you want to introduce yourself?

DR. LIO YU: Yes. I'm Dr. Lio Yu, radiation oncologist. I work in New York. It's nice down here.

(Laughter)

STEVEN SCOTT: I'm Steven Scott. I'm the chief operations officer for SkinCure Oncology.

JOSEPH DANEK: I'm Joe Danek. I'm on the Advisory Council for expert environmental matters.

GIOVANNA MANNING: I'm Giovanna Manning. I'm an environmental specialist for the Bureau. Tallahassee.

GAIL CURRY: I'm Gail Curry. I'm with medical quality assurance. We do the licensing for all the radiologic technologists.

MR. COOKE: Good morning. I'm Douglass Cooke. I'm the substitute Brenda.

JAMES FUTCH: Who's our administrative assistant for the Council.

I'm James Futch, Bureau of Radiation Control. Also based in Tallahassee and I'm council leader.

DR. RANDY SCHENKMAN: Randy Schenkman, Board certified radiologist and the chairperson here.

CINDY BECKER: Hi. Cindy Becker. Good morning. I'm the Bureau Chief for Radiation Control.

MARK SEDDON: Mark Seddon. I'm a medical physicist with Advent health and the vice-chair.

CLARK ELDREDGE: Clark Eldredge, Florida Department of Health. I'm the administrator for the radiation machine section.

GEORGE GILBRIDE: George Gilbride. I'm retired but I'm a certified radiologist assistant and retired from the University of Florida.

WILLIAM ATHERTON: Bill Atherton. I'm a chiropractic radiologist in Miami, Florida and I wish I was retired.

(Laughter)

REBECCA McFADDEN: I'm Rebecca McFadden. I'm the certified radiologic technologist on this committee.

DR. NICHOLAS PLAXTON: I'm Dr. Nicholas Plaxton. I'm a nuclear medicine physician at the Bay Pines VA.

ADAM WEAVER: Adam Weaver, certified health physicist on the Board. Advisory Council.

DR. RANDY SCHENKMAN: Okay. Well, welcome everybody. And we're going to really have -- it looks like this is going to be a fun day, especially when we get to after lunch.

While I'm bringing up lunch, if it's okay with everybody, we were going to shorten lunch from maybe 12 to 1, because two of us have -- we're from Miami and our flights are at 3:10, so we're going to have to leave early. So if that's okay with everybody, we'll just shorten it a little bit. Okay?

DR. NICHOLAS PLAXTON: Sounds good.

DR. RANDY SCHENKMAN: Okay. Now we have -- anybody have something to say?

ADAM WEAVER: No.

DR. RANDY SCHENKMAN: Okay. Now we have approval of the minutes. It's a long list of minutes if people read through them. Does anybody have any questions or comments about it?

JOSEPH DANEK: I submitted my comments to Brenda that I had several editorial and then I just noticed that, and maybe it's common with minutes, I don't know. There was a bunch of, like, hyphens in the minutes as to maybe the -- whatever the person

said was not picked up or something. I don't -- you know, I'm just saying there was a bunch of hyphens in there, in the minutes. If you all look through the minutes, you probably would've seen that. I'm not quite sure what that means, but I gave my comments to Brenda.

DR. RANDY SCHENKMAN: Okay.

JOSEPH DANEK: So I don't know. That's all I got.

DR. RANDY SCHENKMAN: Okay. And I think that it was edited probably based on your comments or anybody else's from the staff. And that -- it's all incorporated in the final minutes.

JAMES FUTCH: If I can add to that. So Brenda, your comments were the very last ones that she got and she incorporated those. And that's actually what's posted right now on the website is the unadopted minutes. And we have a physical copy here if anybody wants to look at it. I think we got several comments internally from staff about a lot of different areas. My staff. And then we had a couple council members mentioned corrections to their sections.

JAMES FUTCH: Okay. So we'll take a vote on approval of the minutes. All in favor, aye?

ALL: Aye.

DR. RANDY SCHENKMAN: Any opposed?

(No Response)

DR. RANDY SCHENKMAN: Okay. We're passed.

Okay. Cindy?

CINDY BECKER: Okay. Well, as far as the Bureau updates, I'll get to that. But we wanted to wish Dr. Schenkman a happy, happy birthday.

DR. RANDY SCHENKMAN: Thank you.

CINDY BECKER: And we're so pleased that her family allowed her to share her special day with us.

REBECCA McFADDEN: Happy birthday.

(Applause)

CINDY BECKER: And we brought some little Cuban, little snacks, pastries over here if anybody would like them.

JAMES FUTCH: And cheese.

CINDY BECKER: There's different kinds of cream cheese, guava. Feel free to have that. And we have to give a little candle. Now this is -- who wants to do the honors?

JAMES FUTCH: You do.

CINDY BECKER: Okay. What kind do you like, Dr. Schenkman? What kind do you like?

DR. RANDY SCHENKMAN: I'll take one of the ones

with the guava in it. The red ones.

CINDY BECKER: Okay. Well --

DR. RANDY SCHENKMAN: That's so nice.

CINDY BECKER: She gets the candle all herself.

JOSEPH DANEK: Guava. I'm from Miami. I like the guava.

CINDY BECKER: You can tell I'm not used to doing this. Okay. So should we embarrass her and try to sing?

GIOVANNA MANNING: Yes.

REBECCA McFADDEN: If we're going to do it, let's do it.

(Singing Happy Birthday)

DR. RANDY SCHENKMAN: Thank you all so much.

(Applause)

DR. RANDY SCHENKMAN: I'm going to make a wish.

DOUGLASS COOKE: Speech, Speech.

WILLIAM ATHERTON: Meeting is adjourned.

(Laughter & Applause)

DR. RANDY SCHENKMAN: And you're all included in my wish.

CINDY BECKER: Nice.

JOSEPH DANEK: That's not going to be in the minutes, is it?

DOUGLASS COOKE: Every key and every note that

was sung.

CINDY BECKER: As you can tell, the new people that are here, we become like family after many years of serving together on the Board. And so, we look forward to many more years. Yay.

DR. RANDY SCHENKMAN: Sounds good.

CINDY BECKER: Thank you.

DR. RANDY SCHENKMAN: Thank you all.

CINDY BECKER: So Bureau updates, I'm even afraid to say this. I have to knock on wood. We almost have a full staff. Poor John and his environmental section keeps struggling with staff. I think they have almost two vacancies right now. But we have a full licensing staff and we have a full inspection staff, so we're good there. And they've been out and about since the very beginning. You know, they took about two weeks off when Covid hit. And I just went out with one of the newer inspectors yesterday. And we said, yeah, they've all done really well. And they haven't had really any issues getting into facilities. So all is good there.

We'll have some updates, you know, from Clark and from Giovanna. Giovanna's representing the --

GIOVANNA MANNING: Kevin.

CINDY BECKER: -- the licensing program today, so you'll hear from her, too.

The other thing, the power plant exercises are coming up in January and February as they usually do, so we'll have a number of staff going to those exercises.

We have an internal applied radiation physics and instant response class where we, over the years, when NRC quit offering free training for us, we developed our own in-house training. It's at John's lab facility, which some of you that have never been there, I invite you all to drop by there because it's a beautiful facility. But they have a nice new training facility there. And they're going to be running our newer staff, about 12 of them, through some exercises in the field, learning how to use the detection equipment, which you'll see some of that later this afternoon. He'll bring some of our newest toys. And they get to play with the toys and get some training on our procedures and processes and it will be a good course. It's a whole week long there at the lab. That's coming up the 13th through the 17th.

And I'm trying to think of what else we have coming up. There might be more exercises. We

usually help law enforcement and others with source support. We provide our sources. And those come up from time to time.

Any other meetings anybody know of coming up? I don't really know of any in the next six months. Hopefully we'll do our, our in-person meeting again probably May, June. So that will happen.

So other than that, welcome everybody. And we'll move on with the, with the --

DR. RANDY SCHENKMAN: Okay. Gail, you're up next.

CINDY BECKER: Gail.

GAIL CURRY: I'm sorry.

CINDY BECKER: Gail. We're going to embarrass Gail too now.

JAMES FUTCH: All right.

CINDY BECKER: It's her last official meeting with us. Miss Gail is retiring.

REBECCA McFADDEN: Congratulations.

GEORGE GILBRIDE: Congratulations. You'll love it.

GAIL CURRY: Thank you. I'm excited. I'm very excited.

JAMES FUTCH: So Gail Curry is the representative from a division inside the

department, the Medical Quality Assurance. Licenses all the doctors and all the different folks, including the rad techs. So I'm going to give a little bit of background on this and see if we can embarrass Gail a little bit more.

So Gail's actually been working for the Department since 2002, if I remember right, and she has worked in the Bureau of Radiation Control and then in 2005, when the alliance between our section and MqA happened for the purposes of rad techs, she transitioned over to work for MqA, and she's been there ever since.

GAIL CURRY: Not by choice.

(Laughter)

JAMES FUTCH: Not any of our choices, but that's kind of the way it worked out. So we have -- had Gail working on behalf of the Council in the Bureau doing some of the background stuff before the transition, and then afterwards in the role that you see her now, which is representative and usually interfaced with the educational program members and help out whatever technologists or applicants couldn't get licensed or haven't gotten licensed in any way, shape or form.

But we just wanted to take a minute and thank

Gail for all of her support over the years and with all of you here, and to wish her the best in her retirement soon, next year some time early.

GAIL CURRY: February 1st.

(Laughter)

REBECCA McFADDEN: She's not counting.

DR. NICHOLAS PLAXTON: She knows the days.

JAMES FUTCH: This one over here has a clock on her desk down to the microseconds.

But we wanted to give you something to remember us by and hang something on your wall, so we've got a little certificate of appreciation. I'm going to read it and then present it to you. It says "Certificate of Appreciation is hereby awarded by the Bureau of Radiation Control to Gail Curry for her 15 years of excellent service to the Advisory Council on Radiation Protection and its members." And we actually have all the current members' names listed down here at the bottom of the certificate. And Dr. Schenkman --

GAIL CURRY: Nice.

JAMES FUTCH: -- and Cindy have signed at the bottom. So if you want to stand up for a picture.

(Applause)

JAMES FUTCH: I think we'll get something like

this. Face Douglass. And you can take pictures with everybody else afterwards if you want to.

GAIL CURRY: Thank you.

Let me just bounce off of that a little bit. This is kind of bittersweet for me because James hired me back in 2002. I knew absolutely nothing about any of this. I mean, I didn't even know what a, a BXMO was. He said BXMO and I'm like, I don't know what the heck you're talking about. And instead of saying radiography, I would say radio-graphy. So I, you know --

(Laughter)

GAIL CURRY: -- it wasn't my world at all. James and --

(Chantel Corbett Enters Meeting)

GAIL CURRY: -- and his staff took me under their wings and trained me very well. So for that, I'd like to say thank you.

JAMES FUTCH: Thank you.

GAIL CURRY: They are my family. They're not my work family. They're my family. And I know I could call any one of them at any time and say, I need something or if I'm having a rough time personally, they're there for me.

So it's going to be hard to leave, but I'm

leaving on a good note. And I'm leaving in a good place for myself. So with that, I say thank you very much.

So let me just --

JAMES FUTCH: Back to the real business.

GAIL CURRY: Yeah. Let me just give, give y'all some numbers like I usually do, and then, you know, I'll open it up for anybody that has questions or concerns or anything like that.

So I am the regulatory supervisor consultant for radiography, EMT paramedics and nursing home administrators. I will be leaving February 1st. We do have a new supervisor that will be taking my place. Her name is Melanie Smith. She's been one of my processors for about three years, so she knows the backside of the processing; the guidelines that's required to license someone, so I think you'll be in really good hands.

They did do a layover or an overlap to -- so that I could train her and I'm trying to give her all the information that I have so that, you know, you guys shouldn't see any major problems or anything like that.

So with that being said, I can tell you that right now, we are processing applications two days

from the day that we receive them in our office. Most of the time, it's been one day. They just knock those out really quick. Right now we are seeing an influx of applications due to graduation so, you know, we do have a little bit more work; it's taking a little bit more time.

Keep in mind we do that with three processors for the whole state. For all of those applications, for EMTs, paramedics, rad techs and nursing home administrators.

There are -- starting January 1st through November 30th, we have -- we've received 2,266 applications for general radiographers, which includes nuclear medicine and radiation therapy. We have five radiologic technology assistants. Those are new applications. And we have 85 of the basic x-ray machine operators, for a total of 2,356 applications received from January 1st until the day before yesterday. So, you know, you guys are growing; looking good.

We have also issued certificates. Now, those were just applications received. We've -- we have licensed 2006 general radiographers, 20 nuclear medicine techs, 35 radiation therapy technologists, five radiologic technologist assistants and 61 basic

x-ray machine operators, for a total of 2,122.

The difference in those two numbers are some applications are not complete. Some may have a criminal background that's in second review. So I think the percentage is awesome. And applications are coming in completed, so we're able to get those done quickly.

Right now -- and I'm not real sure if these numbers are accurate because sometimes when we run the reports versus IT running the reports, they're not exactly the same, but rad techs, including basics, we're looking at 29,485 active licenses. We have 36 active assistants. So your numbers are, are increasing.

JAMES FUTCH: There's one.

GAIL CURRY: Yep. That's why I keep looking at him.

GEORGE GILBRIDE: I was RA26.

(Laughter)

GAIL CURRY: With that, I will just open the floor for any questions; concerns. And please, always know -- well, I'll be there until February 1st. But anything that we can do to help streamline our process or to make things run smoothly, we're up for changing anything we can. Some things, you

know, my hands will be tied because of IT and things of that nature, but I always love getting new ideas and new things, so --

GEORGE GILBRIDE: I have one question.

GAIL CURRY: Sure.

GEORGE GILBRIDE: In the state, you have to keep your, you know, you have to maintain your RT license as well as your RA license. One of the things that a few of the people that I worked with up at UF is when we would put in for -- because both licenses are up at the same time. And a lot of times, like for me and also Sean, he had his RT license, which would be, you get the license for it, and my RA license, I have to make a phone call because they didn't tie in my, my CEUs with the RA. So I just made several calls -- and so did Sean -- and I don't know if, I don't know if that happened with Ken Harbor, either. These are some of the other RAs that worked. And it gets resolved, but it's always a matter of making a couple phone calls so just --

GAIL CURRY: Okay.

GEORGE GILBRIDE: -- they somehow don't have a way to tie them together.

GAIL CURRY: Right. And it's two separate

licenses. So you have to remember, it's two separate licenses. Just because you renew one doesn't automatically renew the other.

GEORGE GILBRIDE: We would send them both in with both of the information. I mean, they would be separate envelopes and we'd get the RT stuff, but it's always a call, oh, okay. And it gets resolved.

GAIL CURRY: Really?

GEORGE GILBRIDE: Yeah. It's just --

GAIL CURRY: You shouldn't have to make that phone call. It should be done. And I will take that back to the office because that -- and especially if you're sending them in separately, they're separate license numbers. They're different modalities, so you shouldn't have to be making that phone call. And that does not actually come through my department. It comes through licensure services.

GEORGE GILBRIDE: I'm sorry.

GAIL CURRY: No, no, no. What I'm saying is, we ultimately could handle that, but renewals go through a different department.

GEORGE GILBRIDE: Okay.

GAIL CURRY: So I need to relay this information to them so that that won't happen in the future. Because when you're sending that in, it

should, it should be handled at the very same time. You shouldn't have to make a separate phone call. So thank you for that.

CHANTEL CORBETT: Are you uploading your CEUs or sending them in with the paper?

GEORGE GILBRIDE: Uploading them.

CHANTEL CORBETT: Do you have to upload them twice or only once?

GEORGE GILBRIDE: Yes.

CHANTEL CORBETT: Okay. I was wondering if it was only one portal maybe that was messing up.

GEORGE GILBRIDE: The last time, it was funny, we were in the midst of moving some equipment and thank goodness, I was, I was, I was on my cell phone and we lost contact and my wife was at our house. We still had the phone working there. And the person called back, got my wife to tell them it's okay, just let them know it will be mailed out properly, because they didn't have my cell phone number.

GAIL CURRY: Yeah. That's another thing. Keep all your information updated. You have that portal. You can go in, if you change your address, you only have, like, ten days to do that. So if you keep all of that stuff updated, we'll have good contact for

you. Update your phone numbers, your addresses, your place of practice addresses. And that way we'll have good contact information.

But thank you, George, for that. That's good information that I can take back for you.

GEORGE GILBRIDE: Okay.

JAMES FUTCH: George, when they set this profession -- when they did the transition from being a purely Bureau of Radiation Control run profession to an MqA run profession in 2005, they set up all of the radiographers and nuclear med techs, therapists and basic machine operators underneath essentially the same profession number in the licensing database. So it's a little bit easier to handle things on that side. So you can be a nuclear med tech and a radiologist therapist, it will all sync up. It will have one license number and it will all renew at the same time.

Gail's group on the front end on the Board office handles applications and thing like that. There's another group she mentioned, the licensure services, and they're used to dealing with the large volume that comes from all of the rest of the professions. So they key in on the profession number. The number.

When they set the radiologist assistants up, it was, it was a few years after that. And for whatever reason, at that point in time, they set it up in their database as a whole separate profession number. So you get this issue of, we think of it as the same, you know, it should be the same, certainly the same person. It should be the same license, but it's handled separately in the, in the system, so we end up having to do stuff like this. But we very much appreciate knowing about it because, you know, we don't know what's happening out there and then it takes a little bit of special --

GAIL CURRY: Hands off.

JAMES FUTCH: -- hands off on the backside to go talk to the right people.

GEORGE GILBRIDE: I don't want to get anybody in trouble now.

GAIL CURRY: No, no, no.

JAMES FUTCH: It's not that. I wish it was just as simple as going and talking to the people.

GAIL CURRY: Let me ask you a question. You said you sent these in by mail. Did you try to do them online?

GEORGE GILBRIDE: I did them online.

GAIL CURRY: You did them online?

GEORGE GILBRIDE: Yes. Look, I'm old enough. I'm used to sending mail.

GAIL CURRY: Well, in our world, that makes a big difference. That's why I wanted to question that.

GEORGE GILBRIDE: I did them online. I uploaded all the information and stuff like that.

GAIL CURRY: So you did try to renew them online and it did not renew one of them. That's really --

GEORGE GILBRIDE: And I got the verification that it all went through, but I only received one license via mail.

GAIL CURRY: Okay.

JAMES FUTCH: It could just be another quirk.

GAIL CURRY: Right.

JAMES FUTCH: Every once in a while, we come across quirks in the different data systems. But we came across one -- it was kind of part of my update, but ties into this a little bit. We came across one that on the renewal applications, there's a question that asks about background history, just like there is on the initial application. If you had a, you know, conviction; this kind of thing. And if you answer yes to it, then you have to supply a bunch of

additional information. It was designed that way; it was working that way. There's only one problem. If you have two convictions to report --

GAIL CURRY: You'd be surprised.

JAMES FUTCH: -- the system gets a little wonky on the last one that you answered, so we've got, as you say, a ticket in to IT to fix that.

REBECCA McFADDEN: I'm thinking, you know, as it only allows you to have one copy of a license, it could be some of the configuration and that's based on, you know, you're only going to generate one per person, even if there's multiple licensures. You see what I mean? Maybe that could be something to look at from an IT perspective.

GAIL CURRY: Right. And that should not be happening, but that could be a good scenario.

REBECCA McFADDEN: Right.

GAIL CURRY: Because there's two separate license numbers or certificate numbers.

REBECCA McFADDEN: Yeah.

GAIL CURRY: So it shouldn't be doing that.

REBECCA McFADDEN: Some of them may be.

GAIL CURRY: It could be. That's a very good observation.

JAMES FUTCH: Kathy couldn't be with us today.

Dr. Drotar. Normally she has a few questions about the many Keiser classes graduating and issues that have happened with them.

GAIL CURRY: I haven't heard from her for a while.

JAMES FUTCH: Yeah.

GAIL CURRY: We're doing good.

JAMES FUTCH: It's working well.

REBECCA McFADDEN: No news is good news.

GAIL CURRY: I'm actually looking at your file and I do see where you did this back in May. May 15.

GEORGE GILBRIDE: Mm-hmm. I feel so naked now.

GIOVANNA MANNING: You're exposed.

(Laughter)

GEORGE GILBRIDE: Oh, God.

DR. RANDY SCHENKMAN: Hide.

JAMES FUTCH: We're recording this for publication on the website. Everybody feel free to say whatever you want.

REBECCA McFADDEN: This is public record, right?

GAIL CURRY: So I -- just by looking at this, everything looks like it went through okay, and both the certificates printed for you on 5-15. Why it didn't get to you, I'm not sure, but I will

definitely look into that.

CHANTEL CORBETT: I was going to say, is your address the same on both?

GEORGE GILBRIDE: Yes.

CHANTEL CORBETT: Some people put a practice address on one and a house address on the other.

GEORGE GILBRIDE: No, they're both the same. I can doublecheck on that. No, they're both the same.

CHANTEL CORBETT: Because we have a lot of techs who forget they put their practice address on it and it goes to a hospital somewhere.

GEORGE GILBRIDE: No, they're both the same.

GAIL CURRY: It gets lost in that big -- yeah, they both are the same in the system, so -- but yeah, that's a great point and I'll be glad to take that back for you.

GEORGE GILBRIDE: And like I said, it just didn't happen to me. It happened to a few other people. I don't know if it's just -- again, I just don't know why, but I haven't heard from anybody else. But I don't really deal with too many of the people other than these other two individuals that I worked with.

GAIL CURRY: Yeah. And I may reach out to you for those names just so I can look at the files and

have some more information to give to IT.

GEORGE GILBRIDE: Sure.

GAIL CURRY: And then that way, they can look at all those --

GEORGE GILBRIDE: No problem.

GAIL CURRY: -- and see if there's a common ground somewhere that will cause that to happen.

GEORGE GILBRIDE: Okay. No problem.

GAIL CURRY: Thank you.

GEORGE GILBRIDE: You're welcome.

DR. RANDY SCHENKMAN: Anybody have any other comments or questions or anything?

JAMES FUTCH: Does anyone see any changes coming from your societies for the professions in terms of nationally, standards changing, things need to change in Florida, or they're not, anything like that? Everybody's happy?

(Laughter)

REBECCA McFADDEN: There was a change, I mean as far as, I don't know, it's not a national society, but I was part of the big society, radiologist technologists that operated out of Ocala. We had as many members as our Florida state as far as registered technologists. We did the -- post the pandemic, we did dissolve that society so

we're no longer operational. And we did leave with close to 60 members who were active and coming to some of the meetings. But the challenge was getting the, you know, getting the support from physicians and people to come and take that time to do the talks and providing those opportunities for the continuing education credits.

But we did, we did dissolve the society and so, but you know, a lot of -- we did, we -- with the funds at the end, we donated to our -- the school, the local school that is run by Marion County School Board. And that was, you know, but after the pandemic and, you know, inability to meet for such a long time, and then, you know, the willingness to get speakers was getting harder and harder. We had about 75 people attend our yearly seminar on a Saturday. It was just a one day. But it's definitely going to be something that's missed in our area and I'll miss, you know, for sure.

But we did have to make that decision and no longer keep it going. It's the online environments I think and more opportunities for CEUs that way. So sad, but --

JAMES FUTCH: Anybody hearing any issues, proposals, legislatures about to go back into

session in January, it's the early year. We keep feelers out to try and see things that might be happening, bills that will affect the radiation issues. But if you hear something, if you -- in your facilities, with your contacts and, and your peers with the societies, if there's something you hear rumblings of, let us know and we'll make sure we keep a watch out for it.

Gail, just out of curiosity, EMTs and paramedics are roughly double the number of licensed folks?

GAIL CURRY: Yeah. They're almost triple your licenses.

JAMES FUTCH: Really? Okay.

GAIL CURRY: They're huge.

MARK SEDDON: I have a question. So the medical physicists licensure, is that through you, Gail?

GAIL CURRY: It is.

MARK SEDDON: Okay. So there's some discussion about licensure for or pathways for physicists who are MR certified physicists. I'm not sure if you had any discussion with the folks at Mayo about that.

GAIL CURRY: I have not heard anything on that.

You know, medical physicists, they don't have a council or anything anymore.

MARK SEDDON: Right.

GAIL CURRY: So it's hard to keep up with the changes that are happening. I have not heard of anything, but I can check.

MARK SEDDON: Okay. Yeah. So just, just make a note that there's been some discussion, there's a pathway for a subgroup of diagnostic physicists who are certified by the -- in MRI only. So they don't fall under the current categories we have as far as diagnostic therapy and nuclear medicine and so they don't have a pathway to become licensed in Florida. And so, it is for some employers who are requiring their clinical physicists to be licensed, they don't really have a pathway for them to move forward.

So it's not a huge group of folks. It's just those who are specialized in MRI. Because they're typically not certified in diagnostic. They're certified in MRI and physics only. So there's been some discussion amongst the board or the chapter, Florida chapter about what pathways or opportunities could be available to them.

CHANTEL CORBETT: Is there only one certifying body for that?

MARK SEDDON: For MRI? Yes, there's ABMP.

CHANTEL CORBETT: That's the only one?

MARK SEDDON: Yeah, that's the only one. But we have -- there's a couple physicists, not many, that are in Florida who are MRI-only certified, so they can't become licensed in -- I think Mayo is the one facility that says, well, you have to be a licensed physicist.

CHANTEL CORBETT: There's a lot of, especially with all the credentialing nowadays.

MARK SEDDON: Credentialing -- with the hospitals, you have to have a license to work --

CHANTEL CORBETT: Right.

MARK SEDDON: -- but there's no way for them to become licensed.

JAMES FUTCH: What's the situation in other states? Has anybody else created a license just for them?

MARK SEDDON: No one else has that. So I did a query around the country. There's some other states that have medical physicists licensure. Nobody has an MRI pathway, so it is kind of unique. Then it's a small subgroup. So again, physics is a small subgroup.

JAMES FUTCH: Obviously, this is outside the

legislation that we would typically look at. The certifying practicing act. Have you looked at the definitions there and is it exclusive of nonionizing? I haven't looked at it.

MARK SEDDON: No. The closest would be diagnostic medical physicist as an affiliated category. But they are not trained. They, they wouldn't include the same scope as far as how it's currently written. Because usually, if you're an MRI physicist, you're non-ionizing only.

JAMES FUTCH: You would think categories as written in the statute would be so robust as to not allow it if they were inclined to do so with regulations and the lawyers were agreeable to it.

MARK SEDDON: Um, I mean, the only -- this is speaking from my opinion. I don't know if this -- my opinion would be that --

JAMES FUTCH: Sure.

MARK SEDDON: -- MRI should be in its own separate category. It doesn't cross over. If you're a licensed diagnostic physicist, then it kind of includes you in mammography and some other areas that typically MRI physicists wouldn't be aware or have that knowledge base. So, I mean, we can't have that problem with -- when you categorize specialties

of physics practice to the extent our current licensure does, it makes it challenging for crossing over.

You know, it would be like if you, if you categorized every type of physician because your license says radiologist only or as a radiation oncologist only, then crossing over those gray area, like, radio pharmaceutical therapy. Like, what is that? A radiology practice or is that an oncology practice? It's the same type of thing you have going on within medical physicists.

CHANTEL CORBETT: Yeah, I mean obviously, nuclear spectrum has its own license, but it's still within the ionizing radiation.

JAMES FUTCH: Yeah. So on -- it could come down to just how strictly that statute's written.

MARK SEDDON: Yeah. So we need to review the statute and look at it. I just wanted to ask if you had any, any discussion about it.

GAIL CURRY: Yeah. No, I have not.

MARK SEDDON: Yeah. There's not really a council, so I think I would primarily go to you with those questions.

GAIL CURRY: Yeah. If something was happening, I would be notified. I have not been notified of

anything like that.

MARK SEDDON: Okay. Well, there's some discussion about that.

GAIL CURRY: Yeah. That's a good --

MARK SEDDON: There you go.

GAIL CURRY: I will go back and ask, though.

MARK SEDDON: Okay. Thank you.

JAMES FUTCH: Going back to the rad techs for a second. We had a little dalliance with an MR certification.

MARK SEDDON: I remember that.

JAMES FUTCH: It fit the national structure. And on first glance, the lawyers who looked at it for creating a license category said yes and then after we issued, I forgot how many of them, a year or two later, somebody complained and they looked at the same statute and said, no, you can't do that. So then we recalled all those MR licenses for rad techs.

But one of the interesting things is the last time we had major legislation that changed our statute in 468 part four, we had some similar problems, which was, look, things change at the national level and the statutes are kind of hard coded in some cases to only allow certain things in

Florida.

So the last time we had our legislation changed, we created a category which we called specialty technologists, which allows for us to, essentially, if there is a change at the national level with regard to, you know, a new category of radio -- any kind of ionizing stuff, we can put that in by regulation without having to go back to the Legislature. Unfortunately, we didn't get the definition of radiation changed to include non-ionizing, so MR is still out at our level as well as ultrasound.

Is that it?

GAIL CURRY: That was hard for us to explain to, to the people that called when they couldn't renew their MR licenses, or certificates. They were like, what do you mean I can't, you know. And so, we had to explain to them that it was pulled back. They liked having that.

JAMES FUTCH: Yeah.

GAIL CURRY: They liked having that.

JAMES FUTCH: It's one of those things that makes sense from the medical and patient point of view. And I think if there was enough demand to change the statute, to put it in, you know, we can

do it, but it takes some effort.

GAIL CURRY: That's all for me.

DR. RANDY SCHENKMAN: Anybody have anything else? Okay. We're going to move on to Giovanna.

JAMES FUTCH: Giovanna? Who's that?

GIOVANNA MANNING: Okay, guys. Again, I'm Giovanna. I've been with the Bureau for a little over a year. It was God sent that I got the job. Thank you guys again for hiring me. I learn something new every day. Kid you not.

But from the last meeting you guys discussed, we're fully staffed, as Cindy said earlier. But you guys -- I guess Kevin mentioned an inspector review position that was open, but he couldn't give you guys a name. His name is Matthew Sension (ph). He's from the Orlando office, which he moved up to the Tallahassee office in our department. But he was -- he's been with the Bureau for over seven years and he was one of the duty officers with the, with the Bureau.

And then Meghan Thorpe, she was our last evaluator, licensed evaluator that came on board. And she got married, so now her name is Meghan Helms.

And the rule making process is still in, in

progress. The rules become effective 20 days after the final rule is filed with the Joint Administrative Procedures Committee. They're shooting for the beginning of April for that -- of 2022, of course.

We also -- I'm not sure, you know, how this applies to anyone in here, but just an FYI. We were getting some licensees who were -- their license was expired and they were still trying to get RAM from pharmacies. And the pharmacies was actually giving it to them. So we just came out with a new fixed paragraph for the cover letter for any pharmacy that, you know, let them be aware that we are, like licensees are amending their license frequently and if they're ordering to try to do a more frequent ask for them to give them up-to-date license.

JAMES FUTCH: Giovanna, on that point, if I remember from previous discussions with you, so you -- the pharmacies were getting a copy of the licensee's original issued license?

GIOVANNA MANNING: Original issue.

JAMES FUTCH: And then not realizing it can change --

GIOVANNA MANNING: Exactly.

JAMES FUTCH: -- before it reaches its

expiration date.

GIOVANNA MANNING: Exactly, or they had multiple amendment requests in between and not getting an up-to-date license.

(Phone ringing)

JAMES FUTCH: George is providing the reminder, on the cell phones, to silence those.

GIOVANNA MANNING: Silence those.

GEORGE GILBRIDE: Sorry.

JAMES FUTCH: That's okay.

CHANTEL CORBETT: Yeah, I mean, it's interesting because Xofigo, specifically Cardinal, has every six months, they email every licensee that is issued for Xofigo for a copy of the most up-to-date amendment. And they tell you, this is the amendment we have on file. If you haven't -- if this is the last one, just let us know. If not, send us the new one. So if they -- everybody would get on that.

GIOVANNA MANNING: Yeah.

MARK SEDDON: I think they're the only ones I'm aware of that usually request it.

CHANTEL CORBETT: Otherwise?

MARK SEDDON: Yeah. I don't know of any other --

CHANTEL CORBETT: No. I agree.

MARK SEDDON: -- any other that submit pharmacy requests --

CHANTEL CORBETT: Unless it's getting ready to expire, which is what made me question that because I mean, even on an original issue licensure, your expiration date doesn't change even though the amendment is in use --

GIOVANNA MANNING: Exactly.

CHANTEL CORBETT: -- so they should at least catch that.

GIOVANNA MANNING: So, well, me personally, I would say, acts every three months, like every quarter.

CHANTEL CORBETT: Yeah. Well, the hospitals are obviously the biggest changers, you know, usually with the AUs going in and out --

GIOVANNA MANNING: Going in and out.

CHANTEL CORBETT: Yeah. Smaller, not as much.

JAMES FUTCH: I think that was -- what I heard about it, it was kind of surprising. You spend all the time and effort to make sure someone is qualified with the license initially and then when they renew it, you think everybody is following it and paying attention to all of it. It's like,

whoops, wait a minute. I think it ran without having a current license. Hmm.

GIOVANNA MANNING: So -- and the funny part was, the licensees who was expired, they were, they were doing a change of ownership in the meantime and the change of ownership had their application in. And you know, they were like, we need RAM. We're like, well, you can't get RAM. And, you know, we had to issue the new license, but then the RSO is the same RSO for the new licensee. So who was responsible to make sure everything is up to date and all that. Yeah. That, that ball dropped so much. So -- but that's something new, which I'm glad that in -- it's now affixed to the pharmacy cover letters. Any other questions pertaining to that?

I have one more statement and then -- medical events, there was one since the last meeting. It was a gamma knife edition. Well, it was a gamma knife licensee. Apparently, if I'm saying it right, there was, like, double the dose, the maximum dose given within the three months' gap, I'm assuming. Whereas this was out of town and they didn't get the, you know, the out of state, they didn't get the records in time to review, so -- but that was --

JAMES FUTCH: Yeah. This one, do you remember this one?

CINDY BECKER: I remember this one, yeah.

JAMES FUTCH: The patient had, essentially, two facilities involved. And the responsible folks at the facility reached out to get the records from the previous ones.

GIOVANNA MANNING: Right.

JAMES FUTCH: And I think they went on vacation.

CINDY BECKER: Right. The treating physician, I guess, left on vacation.

JAMES FUTCH: The person who was filling in, I don't have the exact details, didn't realize it, didn't check when they had it treated and the records came in and said, oh.

GIOVANNA MANNING: Whoops.

JAMES FUTCH: Already treated for that not too long ago.

GIOVANNA MANNING: Yeah.

JAMES FUTCH: Hence the double dose.

GIOVANNA MANNING: Hence the double dose.

CHANTEL CORBETT: One more thing I'm going to bring up on the radioactive materials section side.

So, recently, the Department started asking all

PET licensees, on any routine amendments, renewals, or a new license, to submit either a shielding design or measurements to prove that the public is protected from radiation. So obviously, with new licensees, there's not an issue because they've got a new shielding design. The problem comes in with the older licensees, where most of them probably had one done, but, they don't have a clue as to where they are anymore.

So we've been trying to work with everybody up there to get a routine, easy, across-the-board answer of, what do you do? What do you need us to submit for these clients. So as of yesterday, I think was our last conversation. Basically, they want measurements showing with injected F18 patients in the incubation rooms, your nearest point what those survey measurements would be to prove that you're not -- I asked for the regulation that we're trying to, all of a sudden, ask for these things for, and it was the general radiation protection of the public. So it's -- I feel kind of like we've always done similar things with our MOP.

GIOVANNA MANNING: Right.

CHANTEL CORBETT: So I think it's additional to that. So we've had a lot of clients push back and

say, you know, I've been licensed for 15, 20 years. Why all of a sudden are we having to do this? You know, so it's been a lot of push back on the middle people. Trying to figure out why all of a sudden this is an issue and why it's being asked for.

GIOVANNA MANNING: And I think, what I -- to what I understand, it's being asked for, for when the patient is through. Like, before they leave the facility. Not while they're there, to my understanding.

CHANTEL CORBETT: It's not for the patient. It's for the public. Being protected from the radiation from --

GIOVANNA MANNING: From the patient. Right. Okay.

CHANTEL CORBETT: Yeah. Because they're asking for, like, the nearest area on the other side of the wall kind of thing. Like where did that --

ADAM WEAVER: When they're in the choir room or waiting room after they've been injected. Where they wait for 30 minutes to 60 minutes.

GIOVANNA MANNING: After they've been injected. They want to know, do you guys release them out into the public, you know, or what do you guys do.

CHANTEL CORBETT: Yeah. See, that question has

not been asked.

GIOVANNA MANNING: So that's the issue.

CHANTEL CORBETT: I can clarify that with them, too.

GIOVANNA MANNING: That's the major -- to what I understand.

ADAM WEAVER: Part of the protocol is to keep them quiet.

CHANTEL CORBETT: Yeah.

ADAM WEAVER: Especially if they're imaging the brain.

CHANTEL CORBETT: Yeah. I mean typical is a minimum of 45 at the lowest end. You know, up from that.

ADAM WEAVER: You don't even let them watch T.V.

CHANTEL CORBETT: Right. Yeah.

MARK SEDDON: Who's reviewing that information? I guess there's --

CHANTEL CORBETT: Well, there's no requirement of who provides that information either, so --

MARK SEDDON: Right.

CHANTEL CORBETT: It's the reviewers. The licensee reviewers.

MARK SEDDON: What are they using as the

criteria? Just a member of the public?

CINDY BECKER: Public criteria release.

GIOVANNA MANNING: The release, yeah. Like I said, to my understanding, how I gathered it, it was what do you do with your patient? Do you release them into the public or do you have a protocol for --

CHANTEL CORBETT: That specific question has never been asked.

GIOVANNA MANNING: Okay. Like I said, that's what I got.

ADAM WEAVER: Yeah. That opens up something altogether --

CHANTEL CORBETT: Yeah. There's multiple problems this has already opened up --

GIOVANNA MANNING: Yeah.

CHANTEL CORBETT: -- because, you know, just if you say okay, give me a shielding design, there's no guarantee that they ever put that in. Like, it's telling you what should be in the walls to protect the public. But that's a design.

GIOVANNA MANNING: That's a design.

CHANTEL CORBETT: There's nothing saying that it was actually done. So even on a new facility, if, you know, a physicist calculates that up and

it's a lot of work to do and you give that to somebody, but unless there's actually measurements done after the fact, there's no proof that it's there. And you have a lot people who move into a building --

ADAM WEAVER: A verification survey.

CHANTEL CORBETT: -- that's been used for x-ray or been used for something and they say, oh, yeah, no. It's already got light in the walls. Go ahead and do whatever, you know. So there's just no way to do that without physical measurements.

MARK SEDDON: Right. Because the PET facilities generally have a lot of very heavy duty shielding required for uptake rooms.

CHANTEL CORBETT: Right.

MARK SEDDON: And your design is very dependent upon assumptions --

CHANTEL CORBETT: Locations.

MARK SEDDON: -- how you're utilizing the rooms and how many applications you're putting into the rooms. I mean, you have three uptake rooms, you may assume in your design that you're going to have them equally disbursed, but as you know from a lot of permits, this is our favorite room --

CHANTEL CORBETT: It's closest to whatever,

yeah, exactly.

ADAM WEAVER: They don't have to walk as far.

MARK SEDDON: -- because it's closest -- they have a lot of patients in there. So some of those assumptions would not be accurate. To actually having them, you know, putting the address up or making measurements actually during --

CHANTEL CORBETT: And rooms change, you know. Like the initial design says on the other side of this wall, it's a supply closet. Well, a year later, they decide oh, that's the best place for a reading room and the doctors are going to sit there all day. So --

REBECCA McFADDEN: It's an office.

GEORGE GILBRIDE: Oh, that's okay.

CHANTEL CORBETT: I know. I mean, if their badge -- if you badge the room, I mean, and test things, yes, but you know what I mean?

ADAM WEAVER: They're in the dark anyway.

CHANTEL CORBETT: It's just, this opens up, I think, more liability on the State reviewing, in some ways, like just not knowing exactly what you're wanting us to submit and having it routine across the board.

ADAM WEAVER: They want the MOP to be updated

every year, so --

CHANTEL CORBETT: Right. And we've done the MOP and the MOP goes in with the paperwork on the renewal every time, so, yeah. So that's, that's -- it's still up, kind of in a fluid state at this point. But just FYI, I mean, I thought it was going only on new licenses going forward. But then it came out --

GIOVANNA MANNING: It's going back.

CHANTEL CORBETT: It's on every routine --

GIOVANNA MANNING: Renewals.

CHANTEL CORBETT: -- renewals. They're holding renewals if it's not done properly. So then we're having to get extension letters, which pharmacies don't really care for.

ADAM WEAVER: They don't like that.

CHANTEL CORBETT: They are supposed to accept them, but you know, they give us a hard time on those too. So, you know, that's --

REBECCA McFADDEN: And so this is all part of when you're doing the licensure for an actual lab?

CHANTEL CORBETT: Correct, but only for PET so far.

REBECCA McFADDEN: Only for those facilities performing the PET?

CHANTEL CORBETT: Yeah.

GIOVANNA MANNING: That's what I noticed.

REBECCA McFADDEN: So not all.

GIOVANNA MANNING: No, not all.

CHANTEL CORBETT: I mean, if it's a truly a member of the public thing, it should be for all licenses, not just PET.

REBECCA McFADDEN: Well, what's the difference between the --

CHANTEL CORBETT: Higher energy.

REBECCA McFADDEN: It's the higher energy?

ADAM WEAVER: Much higher energy.

REBECCA McFADDEN: You answered my question. Thank you. The nonnuclear tech over here asked that question.

ADAM WEAVER: Heavily shielded rooms.

CHANTEL CORBETT: No, no. Like I said, I asked for the regulation.

REBECCA McFADDEN: It's the F -- what's the --

CHANTEL CORBETT: F18 for the most part, yeah.

REBECCA McFADDEN: Gotcha.

CHANTEL CORBETT: But, yeah, that's why I asked for the regulation because I thought maybe it was something that changed that I missed. No, it was just the generic protection of the public from

radiation.

Then the other catch is, you know, shielding design doesn't allow you to take away background. So if we do a measurement on an MOP with the background, it still says you're getting this but that dose would be -- you would be getting it even if there was no nuclear facility there. So, you know, do you take -- can you take that away when you do your surveys and say, look, there's nothing additional besides environmental? You know, so you know, that's another question, too.

GEORGE GILBRIDE: So is the concern that once the patient is finished with the procedure and they're out in the public, is that what the concern is?

GIOVANNA MANNING: That was my understanding.

CHANTEL CORBETT: But that's not what's been passed.

GIOVANNA MANNING: But that's not what's been happening. That was my understanding. And that's how I gathered it, so --

CHANTEL CORBETT: Yeah.

MARK SEDDON: That's the release criteria like for iodine patients. Early release. That's a whole different thing.

CHANTEL CORBETT: Correct.

MARK SEDDON: This is design --

CHANTEL CORBETT: Even with iodine patients, now with an early release criteria --

GEORGE GILBRIDE: I'm even thinking about therapy when you treat them with the --

REBECCA McFADDEN: So they want to know what you're doing with these hot patients.

CHANTEL CORBETT: Yeah, but see, that's my problem, like, that's her understanding, but that's not what's been relayed to us. So that's the question. Because we've had to literally submit drawings of the facility and what the surveys are on the other side of the rooms in the next -- like, for instance, my one client has a Chinese restaurant next door that borders that wall. So literally, thank goodness, the tech has worked there forever and knows the owners of the Chinese restaurant. So he says, can I come over and bring a survey meter into your kitchen, you know. And they're like, okay. Okay. I guess if you want. You know, whatever. So I mean, it was background.

But, you know, it's just one of those things that a lot of these tenants -- like, hospitals, it's not a big deal. They own the whole building. But

when you get into the multi-mixed tenant buildings, it's going to be hard to do that because some people are not going to let you get in to get measurements and they're not going to be as understanding.

REBECCA McFADDEN: What about the mobile PETS that show up once a week in some of these practices, too?

GEORGE GILBRIDE: That was what I was just going to ask about.

CHANTEL CORBETT: Yeah, mobiles are whole another animal.

GEORGE GILBRIDE: Whole 'nother breed.

ADAM WEAVER: And they're supposed to do surveys before they start.

CHANTEL CORBETT: Yep. Right. And they're supposed to have cones out and all those things, yeah.

ADAM WEAVER: Yeah. Designate them as a restricted area.

CHANTEL CORBETT: Yeah. It's definitely going to get more complicated before it gets simple.

CINDY BECKER: So Chantel, you said your clients have been conversing with different evaluators --

CHANTEL CORBETT: Yeah.

CINDY BECKER: -- and getting their feedback?

CHANTEL CORBETT: Yeah, we've got Kevin and Joy and Rowena.

CINDY BECKER: Okay. So our group needs to get together and at least help you guys come up with some kind of consistent plan in what we're actually looking for.

CHANTEL CORBETT: Yeah. I mean, I don't think anybody minds doing it.

CINDY BECKER: Right.

CHANTEL CORBETT: It's just I don't want, you know, all the different groups having to submit different things, and if it's as simple as doing some surveys --

CINDY BECKER: Right.

CHANTEL CORBETT: -- that's wonderful. If you're saying we're going to have to go back and do shielding integrities or all these crazy measurements that takes hours of time, then that's a whole another animal.

ADAM WEAVER: You just want the consistency between --

CHANTEL CORBETT: Yeah. Right.

CINDY BECKER: The consistency and one of the things, you know, we are regulated by the Nuclear

Regulatory Commission will come and do audits of our programs. I remember bits and pieces of this kind of coming with Part 37 when they were last doing our full audit.

CHANTEL CORBETT: I figured this is what triggered it.

CINDY BECKER: I think is what triggered it and so I think Giovanna, we'll take it back and we'll get together with the group, because I -- they're coming back in June to do a mid, kind of oversight look at us. They'll do the full-blown audit probably next May or June, 2023 -- 2022.

CHANTEL CORBETT: I mean, I guess the other question that came up was that they are very assumptive that the x-ray section is getting the shielding design submitted for every time a CT gets put in and I don't think that's the case, either. Yeah.

ADAM WEAVER: No.

CHANTEL CORBETT: So I was like, to my knowledge, no. But I am glad I see agreement because I didn't think that that was the case, either. That was kind of what prompted -- they've always been taking care of the CT side of the shielding, but we now need to take care of the PET

side. So I think there's some miscommunication on that as well.

CINDY BECKER: Right. Right. Well, thanks for bringing that up because --

CHANTEL CORBETT: No problem.

REBECCA McFADDEN: She always has good stuff to bring to the table. Give her six months and you've got something good.

CHANTEL CORBETT: If you have the fun clients I do.

REBECCA McFADDEN: You do. You have good stuff that comes up.

CLARK ELDREDGE: I think some of that is from accelerators and making the products. That's where that's --

CHANTEL CORBETT: Yeah.

CLARK ELDREDGE: -- because we've been getting the shielding reports for the cyclotron system.

CHANTEL CORBETT: Yeah. For, like, bulbs and all that kind of stuff, yeah.

CLARK ELDREDGE: That's what they required.

CHANTEL CORBETT: If everything was three feet of concrete, we'd be all good across the board.

ADAM WEAVER: It doesn't work well in the ceilings.

CHANTEL CORBETT: No, not so much. But thank you guys.

GIOVANNA MANNING: Okay.

DR. RANDY SCHENKMAN: So is that --

GIOVANNA MANNING: That's it.

DR. RANDY SCHENKMAN: Okay. Anybody have anything else to add?

JAMES FUTCH: Who can top that? Come on.

REBECCA McFADDEN: No one. Chantel, hands down.

CHANTEL CORBETT: Sorry.

DR. RANDY SCHENKMAN: Okay. So now we're going to go on to our Superficial Radiation Therapy for Dermatological Care.

DR. LIO YU: Before we do that, I'm going to switch chairs. This chair is a little tilted.

CLARK ELDREDGE: I do have a little history here. So in the course, the Council here had a presentation or discussions, I should say, in 2013 and 2014. And in 2013, Dr. Williams had brought a concern up to Council on exactly what's -- what the training is, what's the knowledge base for the use of SRT therapy machines.

At that point in 2014, Dr. Cognetti did present on his history and his experience using a wide range

of radiation, visible light infrared up to SRT in his practice as a dermatologist. Ultimately, looking at the notes, what came out of it is that we want more information. That's what the Council said.

There was a little follow up in September of 2014, but it was briefly mentioned in the meeting notes and nobody, you know, did the true follow up. So this is part of that to follow this up.

When I did my own search to try to find what are any sort of dermatological practice standards or credentialing for dermatologists, I couldn't find anything in my internet searches, but you know, I can't say that that's the end all be all of anything.

While the bylaws of the American Board of Dermatology do say that they have set requirements for, educational training requirements for dermatologists, radiation physicists and radiation therapy, nothing else on their site mentions radiation. When you search for the word radiation on their site, other than in their bylaws. And when you look up their standards for oncology, et cetera, that type of stuff, it all talks about surgery, Mohs and things like that.

There is a document out there that is actually published in the Journal of Clinical Anesthesiology, Dermatology, Aesthetic Dermatology, if I can get it out right. That is actually also posted on Sensus' website. Then it talks about not necessarily the qualifications and whatnot of the individual, the dermatologists themselves, what they should know ahead of time. But what's -- what type of treatment you should be giving and what course of treatment and things like that. That's that focus.

So there's several things that talked about out there I was able to find that talked about clinical practice, but nothing about who should be doing it, how they should do it, what their backgrounds should be; that type of thing, which if you look at our other radiological, our therapy posts, there's generally -- there's something about who's behind the button.

The CRCPD, CRCPD, has no -- in their state -- suggested state regs, really makes no differentiation on any type of radiation therapy, the use of radiation oncology, radiation type of stuff, you should have a gamut of therapists, oncologists, medical physicists and the team working on this.

Now, of course, in dermatology, it's not just sarcomas, basal cells and whatnot. They're also doing other skin conditions which don't respond well to surgery. They will treat those with radiation as well.

So looking this up, trying to find more background for you all, whatever, you know. So that's why it's important these folks are here today to help us see -- explain what they are seeing in their world.

So I appreciate you all coming today to talk to us on this. Anything else I wanted to point -- currently, we do have on our registration, eight Grenz Ray machines, one ultra voltage, 75 SRTs, looking for use code rather than model name in our databases. And the SRTs are currently all Sensus and Xoft has also contacted the Department with plans to market their EB IORT in an SRT mode because they've got an add-on kit that converts it to an SRT usage rather than electronic brachytherapy or intraoperative radiation therapy. So -- anyway, that's my --

JOSHUA SWINDLE: Great. Well, we appreciate you guys and are grateful, you know, to be asked to be present here. And, Clark, thank you for engaging

with me and we've been working with the Department of Health here in Florida since early 2016 with our model. We have about a dozen practice partners that are here in the State of Florida that we work with. We do have about 200 practice partners nationwide; about 250 Board certified radiation therapists that report to us.

And then let me make introductions. So this is Dr. Lio Yu. He's a radiation oncologist that works with SkinCure Oncology and our practice partners. He's also the author or co-author of the largest superficial radiotherapy study, clinical evidence based study that's ever been, you know, achieved. And that, that is from the place of service dermatology with authorized users; dermatologists.

This is Steven Scott. Steven is our chief operating officer of SkinCure Oncology. He also is a Board certified radiation therapist with a long history within free standing and hospital-based radiation facilities.

So my name is Joshua Swindle, Board certified radiation therapist. I oversee the practice operation side for SkinCure Oncology. I really give a lot of the leadership and support to our practices and to our clinicians that are utilizing superficial

radio therapy.

So Steven, anything you wanted to add?

STEVEN SCOTT: Yeah. Again, we appreciate you guys inviting us to be here today and ordering up this amazing weather. This is just fantastic. We appreciate it.

You know, one of the main reasons that we decided to form SkinCure Oncology back in 2016 was because we knew there were a lot of dermatologists wanting to do this. And if you went out there and looked at 100 different practices, you would literally see 100 ways of doing things. So coming from a hospital-based radiation oncology background, what we wanted to do was create an environment that was all about patient safety, right?

So since we knew how to do it in cancer centers, we thought why couldn't we consolidate this little model and make it work in a dermatology space. So that's exactly what we did. And to date, our practice partners have treated approaching 35,000 patients nationwide.

So, you know, there's no shortage of skin cancer, right? Over 5 million new diagnoses every single year. You guys, a big chunk of that is in Florida, by the way.

(Laughter).

STEVEN SCOTT: Yeah.

REBECCA McFADDEN: It's the weather.

STEVEN SCOTT: And because of our background, because of the folks that we knew, that's when we decided to make all this happen. And so he's going to get into a lot of the nuts and bolts of what makes the program work. And Dr. Yu can talk a little bit about the protocols that have now been established and our, essentially, the nationwide protocols being used specifically in image guided SRT or IG-SRT.

But over and above the requirement for making certain that the dermatologists who, in this case, would be the authorized user, is going to be well educated over and above the manufacturer's training. And again, we're not the manufacturer. We don't sell devices. They, they do a very comprehensive training for these guys on the front end, right?

You know, Clark, as you mentioned, it's kind of vague as to what you will find out there as far as the resources for how these guys are trained. Forty years ago, they all knew how to do it. They all had these things in their offices and since they are the gatekeepers and patients are self-referring there,

it's obviously really important that they get proper training. So the manufacturer does training for them and then we do training for them over and above that with regard to appropriateness of use and, you know, what patient is a good patient and what patient is not a good patient for radiation. Making sure that they understand all of that. How that's all going to work. And Dr. Yu oversees our grand rounds that happen on a weekly basis nationwide for how they discuss more complex cases or something that might be a little bit unusual.

So, you know, if you take anything away from my part, which I promise I'll shut up because I know we have a schedule to be on here. It is that this was established, first and foremost, for patient safety. Okay? We have very, very comprehensive radiation protection programs. We certainly understand the spirit and intent of CRCPD Part X, which basically everyone has adopted, and what needs to happen so that everybody feels confident that somebody has not just gone off the reservation and is doing something out there maybe possibly hurting a patient, or operating in an unsafe way, where we have mechanisms that, you know, use record and verify systems, use medical physicists, have radiation oncologist

oversight, again, weekly grand rounds. Looking at everything and anything that needs to be addressed so that when you guys do provide authorization for an authorized user and grant that registration, hopefully you guys feel very comfortable on what has been submitted to you on behalf of that practice. Knowing they have initial training and as much ongoing training as they would like some of the states out there do require the authorized users, dermatologists in this case, to have annual retraining again. And that's something we provide to any of our practice partners who want this.

We only use the best of the best technology. That is the Sensus SRT-100 Vision unit, which is image guided. It has a record and verify feature built into it.

Again, we have medical physicists on board as well. We have two full time; we have two part time and then we have a handful that are contractors so that we have some overlap and some continuity of care just in case something has to be done. Every chart gets checked every fifth fraction. Every patient's calculations get checked by a third fraction. You know, just exactly like you would see in a cancer center and making certain, again, that

these dermatologists are really well versed. They really know what they're doing and, in fact, from our perspective, if we see a dermatologist operating in an unsafe fashion, obviously we would bring that to their attention. And if they, if they won't change their ways, if you will, we divorce ourselves from them. We won't be associated with the practice that's not going to do it right.

We're also really, really stringent on reporting of any misadministrations, right? And some of the states have actually been quite surprised when we know there was a misadministration and we made certain it was reported and a corrective action plan was put into place. I'm very happy to say, over those 35,000 patients that have been treated, there's only been five or six misadministrations in the entire country, but all of those were followed up accordingly; additional safety procedures were put into place to make certain that, you know, hopefully that never happened again.

But that's a real high-level overview of how we came up with the thought process for developing SkinCure Oncology and with that, I'm going to turn it back over to Josh. Go ahead and roll through the

PowerPoint.

If you guys have any questions during any point of this, please raise your hands. We'll be happy to address them. But for the sake of time, we'll get it rolling.

JOSHUA SWINDLE: Great. Thanks, Steven, and yes, please, feel free interrupting. I do want to breeze through the PowerPoint relatively quick so we can save some time for conversing.

As far as our mission goes, it's "to empower patients and dermatology practices by providing the highest level of education and expertise needed to deliver superior outcomes for non-melanoma skin cancer." I think that really aligns with the Florida Department of Health's mission, which is to protect, promote and improve the health of all people in Florida through integrated state, county and community efforts. So our missions are very much aligned. It's having accessibility to patients and making sure that it's done in a safe manner.

As far as the floor of our model, we really have a cancer center model. You know, the three of us come from free standing and hospital-based cancer centers, so that's all we know. How to provide a really appropriate radiation protection program

within the dermatology space under the supervision of a dermatologist.

So part of that program, obviously, is radiation safety officers. Radiation facility protocols. Utilization of a Board certified radiation therapist. In this case, also state licensed within the State of Florida. To beam on under the supervision of the physician. Medical physicists, as Steven mentioned, that's just not for initial and ongoing calibrations, but we use our medical physics team for quality assurance on the technology throughout, you know, operations as well as quality assurance on the patient prescriptions.

And then access to radiation oncologists. We have Dr. Lio Yu. He works very close with our chief medical officer that is a Mohs surgeon out of Texas. They are constantly reviewing outcomes; they are constantly reviewing protocols. They provide a weekly grand round that is hosted by them; that is accessible to all of our practice partners; mandatory for all of our radiation therapists to attend.

There's times that, you know, maybe I'll have Dr. Yu speak on this, but the presentations are done to where very difficult cases that, you know, you

could have a, you know, clinical outcome jeopardized by not providing the best protocol.

So, Dr. Yu, do you want to speak on some of the interesting cases that have come across at grand rounds and why that's beneficial to our practices?

DR. LIO YU: Yeah. Sure. So first of all, thanks for inviting us. And just to give you a little background, I've been a radiation oncologist for almost 30 years, so I've treated all kind of cases. A lot of cancer cases. Mostly really advanced cases. Because the dermatologists always send the train wrecks to the radiation oncologists. The other ones, everybody gets cut. The early stage cancer patients, they get cut and I feel that's unnecessary surgery.

So for about twenty plus years, I've been trying to convince the dermatologists that radiation works really well. There's no scar. So I was really thrilled when SkinCure Oncology had this endeavor and I saw the model was excellent. They take the cancer center model and applied it to the dermatology world.

So we got to -- part of my responsibilities, besides doing -- helping them with some research, which is education, weekly grand rounds that we run.

We have the therapists from the different practices present difficult cases. And, and these cases are important because sometimes, they don't realize that there could be a pitfall. For instance, you have overlapping beams. If you're treating one side of the nose, the other side of the nose, you know, even though it may be three months later, it could be a problem with the septum getting the necrosis because you're getting maybe double the dose or, you know, extra dose that you shouldn't be. Or contour differences. Sometimes they have the nose going into the cone and it goes in several centimeters, and they don't realize, oh, the tip of the nose is actually getting 200 percent of the doses.

So, so these things are important to point out because it's not always obvious. So, so it's really nice to have a venue where they can, on a regular basis, ask their questions. And the people who are listening, they, they realize that if they get the same situation, they know what to do.

JOSHUA SWINDLE: And as Steven mentioned, our practice partners have treated over 35,000 patients to date with a 99.3 percent cure rate. That was in a recently published study that Dr. Yu was a co-author on.

And satisfaction, you know, patient satisfaction is, is really critical. And that's exceeding 99 percent. Patients love having this option. It is new; it is innovative. There's a huge adoption right now within the dermatology space because there's a big need. You know, 5.4 million cases diagnosed on an annual basis that, you know, requires treatment. And the majority of those patients have been receiving surgery as their sole treatment or if they don't want to have surgery or they've come too late in the game, they're having such an advanced case that they're requiring a mega voltage style radiation treatment and possibly even systemic treatment.

So when I was speaking with Clark about where we could, you know, come in and help -- and we love to be an industry expert and, you know, give any sort of guidance that we can to the State of Florida -- I look at this as far as risk versus benefit. You know, what are the risks of this being within the dermatology practices? And the risks right now, from what I can perceive on some practices that we, we have come across is, you know, radiation protection programs. What do the inspections look like from the Department of Health?

What do the radiation protection programs look like for their ongoing operations? We always say that the radiation protection program binder is really kind of the Bible of the program. And it's a good look into what the practices are really doing on an annual basis.

Quality assurances. You know, what quality assurances are in place to make sure that the safety and efficacy is there? Who are your authorized users? Are we using appropriate clinicians for the delivery? Are we using appropriate clinicians as the authorized users? What is the training and then, the biggest risk is that we button the regulatory up too tight to where it's inaccessible to people of Florida. Obviously, Florida has a large need for this particular cancer.

So benefits of it being in the dermatology setting is the incidence. There's a large incidence of these skin cancers that require a non-surgical solution. It's a place of service that it's diagnosed. If it's not accessible within that place of service, more than likely, the patients are going to have one option and that's surgery.

There needs to be a safe and non-surgical solution there. So with the appropriate model, you

can have a safe and effective delivery of superficial radiotherapy services.

So the technology and training and safety, this is, you know, the particular superficial unit that SkinCure Oncology utilizes. There are other manufacturers out there. Sensus Health Care has a couple of different types of technologies. This third-generation technology really provides the highest level of care and safety measures from our perspective.

So this is the SRT-100 Vision unit that is manufactured by Sensus Health Care. And as far as the unit goes, this particular unit does have an onboard dosimetry program. It has a cloud-based electronic health record that allows our medical physics team to do reviews on those prescriptions that are in place. It allows them to do reviews on the daily checks that the radiation machine goes through on, on, you know, for quality assurance and quality checks. And then it has record and verify, just like you would find at a health center environment. It has a verification that what was delivered yesterday is being delivered today. So again, multiple safety measures in there.

The therapist does a warm up on the technology

and if it's outside of any sort of thresholds, the technology will not allow the therapist to beam on. So, again, as far as the technology goes, we believe that it is the highest level currently and it provides the most safety measures.

So, and then the training. What training is being completed? Steven had talked about the manufacturers providing training to the dermatologists prior to, you know, being able to utilize the technology. And then we really take it a step further and do an extensive clinical training with, you know, the subjects of radiation safety, physics, the manufacturer's training I mentioned, clinical applications, user training and really best practices. So those are the training environments that we, we, you know, spend the most time in.

There is ongoing training that is accessible to the dermatologists and to the practices as needed. And as Steven mentioned, there are some states that do require that annual, you know, refresher trainings or annual hours are submitted for, for training.

So as far as assurances on the safety and efficacy, really, our radiation protection binders and our programs that -- there's a monthly

checklist; there's an annual checklist. There's specific dates that must be accomplished in each of our programs.

So the clinicians that we, we believe are most appropriate would be a Board certified radiation therapist licensed within the State of Florida to deliver the treatment under the supervision of a physician and/or a physician to deliver the treatment. Those are the two individuals that we find to be the most appropriate. And then having that medical physics support that we've mentioned several times on the quality side.

You know, as far as physics goes within the, you know, superficial realm, superficial is still delivering therapeutic doses of radiation. It's very high doses of radiation and there is, you know, potential danger and having that medical physicist as a safeguard and doing those spot checks, spot checks are critical. That's what allows us to catch things before things could occur in the misadministration.

As far as our protection program, I'm not going to read through each of these, but these are the items that we cover extensively with our programs. We have, you know, again, processes and safeguards

in place to make sure that these things are reviewed quite frequently so that when the Florida Department of Health walks in, it does an inspection, the inspection goes extremely smooth and easy and we know that our patients are being treated appropriately.

JOSEPH DANEK: I've got a question for you.

JOSHUA SWINDLE: Yes, sir.

JOSEPH DANEK: I noticed you had film badge reports on there. Do you use film badge rather than TLD, thermoluminescent dosimeters or OSL? Is the film badge the method used for personnel monitoring? Why film badge?

CHANTEL CORBETT: No. It's probably GSLDE. It's just a generic.

ADAM WEAVER: I think it's just radiation dosimetry.

STEVEN SCOTT: It's just personnel monitoring.

CHANTEL CORBETT: Yeah.

JOSEPH DANEK: Well, it's personnel monitoring, but it's probably not film badge.

CHANTEL CORBETT: It's not true film anymore.

STEVEN SCOTT: No.

JOSEPH DANEK: Yeah, right.

STEVEN SCOTT: So if -- there are a couple states that actually require us to do an annual TLD

reading output on the machine separate and independently, so obviously, we take care of that as well.

JOSEPH DANEK: Okay.

STEVEN SCOTT: We actually are kicking around now, moving to the new electronic personnel dosimeters. It's just a hell of a lot cheaper, but that probably will be something we move into next year.

JOSEPH DANEK: Okay. Thank you.

WILLIAM ATHERTON: Also a Question on the shielding, so these are going -- you're trying to put them in dermatologists' offices. How is -- does it -- is it designated in one room and then how, how do you do the shielding for that room? Is it usually extensive?

ADAM WEAVER: Does it require shielding?

JOSHUA SWINDLE: It does require shielding. So, yes, it is done within, you know, a free-standing physician office. Typically, the, you know, size of the room is ten by ten or an exam room. The shielding is created by our medical physics team. So our medical physicist will look at the output of the technology, the expected run time, utilization of it, and they will create a shielding

report that then is submitted to the State.

And then we have a team that all they do is build outs for, for this particular instance. They use lead-lined gypsum board that they would come in and they would lead line and create a superficial vault.

WILLIAM ATHERTON: Physically alter the room.

JOSHUA SWINDLE: They create a little micro vault. So it is lead-lined gypsum board, though. And then medical physics, upon that initial calibration, would come in and do any sort of area surveys and, and make sure that there's no leaking.

DR. NICHOLAS PLAXTON: Is it gamma radiation?

ADAM WEAVER: X-rays.

JOSHUA SWINDLE: It's X-rays. Electronic, yeah.

WILLIAM ATHERTON: Are there any safeguards --

DR. NICHOLAS PLAXTON: Scanner. Same thing.

ADAM WEAVER: Photon.

WILLIAM ATHERTON: Is there any safeguard -- so that machine looks mobile to me. Is there any safeguard with the machine staying in the room?

JOSHUA SWINDLE: The machine does stay in the room. Within our practice partners, there are some practices that might move their machines from facility to facility. We, you know, we think that

having it in one room is best. And make sure that the machine isn't jostled around and that it falls out of calibration or safety.

It is mobile within the room. So you have some wiggle room to move it.

ADAM WEAVER: So you can stick it in a corner when you're not using it?

JOSHUA SWINDLE: Exactly. It stays within that exam room.

MARK SEDDON: How would you guys say your RPP compares to, like, the standard in the industry for dermatology offices as far as physicists? Yours is pretty elaborate involving oncology and physicists and, you know, qualifications. Is that what you would consider standard for a lot of the dermatology offices that have Sensus?

JOSHUA SWINDLE: I would, I would say probably not.

MARK SEDDON: Right.

JOSHUA SWINDLE: We have adopted practices that have been stand alone prior to our existence. And they have asked us to come in and aid with their radiation protection program and essentially convert to our model. Part of that conversion is taking a look in the closet and, you know, finding out what

we can do to improve the safety standards and the radiation protection program.

Again, with you know, Steven, myself, Dr. Yu coming from hospital based and free-standing cancer center, we wanted to create a standard of care that is essentially the same within those settings but within the place of service dermatology.

MARK SEDDON: So for, for Clark, you asked him, so for the other -- not these guys, but other facilities that use SRT in Florida, do you, do they submit the shielding designs to you folks?

CLARK ELDREDGE: They have to use surveys. Well, our codes cover -- we have above -- we have a code for over MeV, under MeV and brachy, right? So under MeV, we require surveys. Post whatever -- we don't require pre-submission of pre-designed plans. We do require pre-designed plans in the MeV and above facilities for therapy. So -- but they do have to have -- they have to do a post build-out survey, showing that they're going to -- calculations to show they're going to keep public doses down, et cetera.

MARK SEDDON: Right.

ADAM WEAVER: What's the typical energy, the x-rays, being generated?

JOSHUA SWINDLE: Grindstone 100kV with this technology. So the typical energies that are utilized with non-melanoma skin cancer treatment would be 50, 70 and 100kV.

ADAM WEAVER: Does it vary the energies during treatment or are you looking for the different depths?

JOSHUA SWINDLE: It can vary. So one of the benefits of having the image guidance component, which is an ultrasound-based imaging, is you can provide an adaptive radiotherapy approach. So if you see a significant change in the lesion depth or, you know, need for an adjustment in the energy, that can be done in realtime.

MARK SEDDON: And is that decision made by the therapist?

JOSHUA SWINDLE: By the authorized user physician.

MARK SEDDON: The physician.

JOSHUA SWINDLE: So the radiation therapist, just like you would find in a cancer center environment, they would do the imaging and any adjustments to protocol would be decided by the physician. So the authorized user physician would say, you know, based on the imaging, yes, we do need

to adjust our protocol to X.

MARK SEDDON: Okay. But you wouldn't have -- you don't have direct physicists to change plans. It would just be --

JOSHUA SWINDLE: There's direct access to the physicists, but the authorized user is the prescribing, you know, physician in this case.

MARK SEDDON: Right.

REBECCA McFADDEN: Do the dermatologists get additional certifications from a dermatology standpoint?

JOSHUA SWINDLE: Say that one more time.

REBECCA McFADDEN: If the dermatologist is the one who's prescribing and you're saying that he's an authorized user, does -- would he require additional certifications in order to do that from a dermatology standpoint?

STEVEN SCOTT: NO, not additional certification, no. No. As physicians are the healing arts, you know, they do get some of this exposure in school. Some of the older docs that are out there, the old-school guys, they know a hell of a lot about this.

REBECCA McFADDEN: Right.

STEVEN SCOTT: The younger guys, not so much,

right? But what you're seeing is a lot of the younger guys coming out of school now wanting this because they've seen how great the outcomes are and now with the third-generation technology, a lot of them are wanting to adopt it.

But, you know, to your point, what we don't do is, we don't just say, well, you've had the manufacturer's training. You've been deemed an authorized user by the State. Good luck. No. There's quite a bit of work that goes in to make certain that they understand what is clinically appropriate and what is not.

MARK SEDDON: The gap, right, would be the clinical radiation oncology, radiation biology piece is that most of them do not have and the training.

JOSHUA SWINDLE: And we have the luxury of having the support from, you know, kind of that mile-high view that anything that is not, you know, within a pretty little box, that that can be submitted and peer reviewed by multiple physicians. We do have, you know, Dr. Yu. We also have another radiation oncologist that works with us and we have several dermatologists that have been doing this for a long period of time.

REBECCA McFADDEN: Right.

STEVEN SCOTT: And sometimes we do involve the medical physicists depending on what the set up might look like. It might be an unusual set up we need some help with. You know, maybe because of the obliquity of the beam or, you know, because the lesion is changing so much in realtime. You know, back to your point. This is not like treating a lung or, you know, prostate or something. I mean, you see significant changes, quite literally, on a daily basis.

The other thing, too, is because the technology does have the ultrasound capability, it also has a Doppler feature, which is pretty amazing because, yes, we want to make necessary adjustments to the lesion as a doctor prescribed, but by the same token, you also want to look at that subdermal layer and see what's going on from a vascularity and repopulation perspective. Unfortunately, the practices that don't have image guidance have to make a call. I'm going to use 50, I'm going to use 70, I'm going to use a hundred. Why? Well, because that's what I'm comfortable with.

This is actually prescribed to a depth based on the imaging on the front end and then they can watch it, because there's no need to over radiate, right?

Just because the doctor has prescribed 5600, you know, doesn't mean you have to give 5600 with 100kV, right? Because you're going to blast it. But you may have a spiculation that goes off obliquely from, from the dermal layer that is into some of that dermal fat that needs to be taken care of. So we do make adjustments in the energy and the daily dose.

And then there's also the consideration of the normal granularization of tissue down below all of that because you don't want to just destroy that tissue in the process. It really is the best of all worlds.

WILLIAM ATHERTON: I have a question just on the selection of lesions; how that works. Like are these, does it have to be, like, a biopsy-proven cancer before they use this?

STEVEN SCOTT: Yes.

WILLIAM ATHERTON: It's not like, that's a suspicious mole, let's use this.

STEVEN SCOTT: No, it doesn't work like that, no. Very, very rarely would you have a case that needed to be treated without a biopsy. It would be just like you would see in a cancer center. Every once in a while that does happen, right?

But, no, no. All these patients are going to

have positive pathology. The doctor has looked at it. It's actually fairly easy to look at skin under a chromatoscope and kind of know right away when you see the pearly edged, yeah, this one is probably going to come back positive.

The only one that falls outside really are keloids, right? The radiation is incredibly effective for keloids. I'm an old-school radiation therapist since the 80s. I've treated, I don't know how many keloids. I've never had one come back. And so, you know, if any of guys have ever have a family member or yourselves having ever dealt with a keloid, it's awful. It's painful. It itches. It causes adhesions. And so a lot of the practices are utilizing radiation now rather than just injecting it with Kenalog -- which we all know doesn't work -- and getting amazing results in controlling those things. It just takes three fractions, about 18 grade, to knock them out.

DR. NICHOLAS PLAXTON: I just have an overall question. It sounds like the patient has to come for multiple visits, right? Like, what's the typical treatment? Like, how many sessions do they have to come to? Because it seems a lot more complicated than just cutting it out and throwing

it --

JOSHUA SWINDLE: Yes and no. I mean, the method is, surgery is one done, right? But there's also post-op wound care.

DR. NICHOLAS PLAXTON: Right.

JOSHUA SWINDLE: There are several factors that are in there for surgical incision, especially a very advanced surgical, you know, procedure such as Mohs.

So as far as the treatments, they're, you know, typically delivered three to four times per week. The sessions are anywhere from, you know, ten to fifteen minutes depending on the quantity of lesions or the complexity of the set up. But the patients are able to walk right in; walk right out. And, you know, three to four treatments per week over five to six-and-a-half weeks.

DR. NICHOLAS PLAXTON: So it's a time commitment then.

JOSHUA SWINDLE: It's a time commitment. The majority of patients that are getting diagnosed tend to be in a retirement stage.

DR. NICHOLAS PLAXTON: Sure.

JOSHUA SWINDLE: Luckily, what are they going to do spending their time? They actually enjoy

having, you know, that routine physician visit. They -- it gives them something to do; gives them some purpose for sure.

DR. NICHOLAS PLAXTON: It seems like the complexity, though, would dramatically increase the cost of this thing being treated than, you know, just a dermatologist cutting it out. Like, what's the cost difference? It seems like it would be dramatic.

JOSHUA SWINDLE: As far as cost difference of the, like --

DR. NICHOLAS PLAXTON: Yeah, radiation versus --

JOSHUA SWINDLE: -- what the reimbursement would be? Honestly, they're within the same playing field. You know, when you really look at apples to apples, you know, of surgeries that might require reconstructive surgery, you know, any sort of plastic involvement, any sort of, you know, poor outcome from a surgical, you know, failed wounds, and then you look at what little toxicity and little complications there are with this particular device and appropriate protocols and the quantity of lesions that are treated at a time.

You know, the average lesion per patient is 1.7

lesions. And so, with radiation, we typically treat, you know, up to three lesions at a time; whereas surgery is done one at a time. So if you look at a true cost comparison, they're really within the same playing field.

CHANTEL CORBETT: And most insurance companies are open to either option? Or --

JOSHUA SWINDLE: Sure. Yes. Most, most payers are, you know -- I mean, the payers are payers. I won't put anything on the record about payers, but --

CHANTEL CORBETT: Right. Well, I know sometimes they really try to steer towards --

JOSHUA SWINDLE: They do.

CHANTEL CORBETT: -- one or the other.

JOSHUA SWINDLE: The least expensive option they can for patients. But, yes, most payers, both federal and commercial, are reimbursing for, you know, this particular service line.

STEVEN SCOTT: Yeah, but most of them now are following the NCCN guidelines which have been recently updated and radiation is a first-line therapy now for non-melanoma skin cancer. So obviously, we're selfish to what we do, but by the same token, we think every patient ought to have

every option available to them and not be shoved into one thing or the other.

DR. NICHOLAS PLAXTON: You were talking about the elderly patients. Like, you know, I know, like, surgery tends to -- you have problems with, like, wound healing and whatnot. Like, does this -- has there been a study showing this has, like, a better outcome from that? Like, can you get, like, wounds that are caused from this radiation that don't do well, I guess, in elderly patients?

DR. LIO YU: Well, this -- the protocol that we use is something that's kind of, in the radiation oncology world, a middle-of-the-road type of treatment. If you went to a cancer center, the treatment would actually be much more, much more frequently. Like five days a week and be about six and a half, seven weeks. About 30 to 33 treatments. Typically, it would be about 20 treatments, because these are small lesions and they don't need to be treated every day. So it's kind of a middle-of-the-road situation.

Now, on the other end, you have some people that are, like, in nursing homes and there -- they, they want to be palliated quickly. They could be given much faster fractionations. But it's the risk

of having some ulceration complications.

So in the study that we did about 3,000 cases, the safety is excellent. In fact, only grade one, mostly grade one arrhythmia; some hyperpigmentation that occurs on these patients. Very rarely do you have anybody who has even, you know, moist desquamation. And I think it was like maybe one or two cases out of the 3,000 that had a grade, like a grade three toxicity.

STEVEN SCOTT: And we certainly have seen, in some of the practices that we've been brought into, patients that are coming in for follow up that they treated, you know, two years ago before SkinCure Oncology even existed kind of thing, and they were really rushing the fractionation. They were doing it in six fractions, maybe eight. The risk of, of significant breakdown, ulceration, goes up substantially. You start treating in 12 fractions or less, you're going to see something greater than 20 percent of all patients end up on brach. And some of those patients, sadly, will end up in hyperbaric wound care and have to have constant debridement. Those things just don't want to heal if you get after it really fast.

But we also see a lot of complications on the

Mohs surgery side. Anything below the knee on an elderly person, you know, is almost impossible to heal. Most of these patients are on some sort of a blood thinner. It's -- there's a lot of reasons, good reasons to have radiation if it's done appropriately. You know, and we're actually very, very proud of the protocol that we support. It was jointly developed with Dr. Yu's help as well, which is what we think is a good balance. And that is, you know, it's really difficult to tell a patient who doesn't believe they're dying, that you've got to come in 33 times, right? If that happens in a cancer center, of course, the patient is going to say, yeah, I'm coming in.

But to say to a patient, okay. We want you to come in 30 times to your dermatologist's office, even though 30 fractions would actually be safer, right? We can all get behind that. It's a difficult ask. And so stopping it at 20 is what the radiation oncologists have felt comfortable with that we can deliver a tumoricidal dose and have very, very minimal number of patients that have bad outcomes or end up on brach.

But it is interesting, like Josh mentioned, that, that genre of patients, they're people kind of

people. They love to see folks and say hi and stuff like that. They get actually very attached to their radiation therapist and they get to where they enjoy coming in and being seen. And it might be the only opportunity they have in their life to not be sitting in a room naked in a paper gown waiting an hour and a half for the doctor to show up. They literally drive right in, they come right back, they get treated. It's, you know, it's a great quality of life. It doesn't preclude them from doing anything they want to do.

What comes to mind is a guitar player that I treated years ago in Austin. He was very worried about losing the use of his hand because that was his livelihood. And so, you know, we did perform radiation on it. He had an amazing outcome. He is still performing live today. So it's not just for people who have stuff on their face. Although we can, I think we can all understand, you know, people don't like scars on their face per se.

So a lot of patients do ask for this type of treatment. And, you know, there's only a handful of centers out there right now that are performing IG-SRT. Hopefully that changes in the future and it's available to anybody in any state.

JOSEPH DANEK: What's the typical treatment dose? The range of dose treatment. I know it depends on the cancer. But just typical cumulative total treatment dose applied?

STEVEN SCOTT: Between 5 and 6,000 centigrade.

JOSEPH DANEK: Between what?

STEVEN SCOTT: Between 5 and 6,000. Usually it's around 5400 to 5600 is usually the tumoricidal dose delivered. Delivered at about 275 centigrade per day, three to four days per week.

DR. NICHOLAS PLAXTON: The other question I have is, like, with different modalities, especially like the face, like I mean, I know they use, like, immune therapy creams, right, for -- which essentially is not going to leave a scar, either, and you just apply that for, like, a month or two, right?

DR. LIO YU: Well, it's not that simple. The new targeted agents for basal cell are called Erivedge and they have also one for squamous cell. The response rate is, the complete response rate is only about 40 percent. So even though they're using that, it's not -- most of the cases, it's going to come back. So even though they're getting it, they still need to have primary treatment, whether it's

surgery or radiation therapy.

ADAM WEAVER: Follow-up treatment.

STEVEN SCOTT: Yes, sir?

WILLIAM ATHERTON: Do you see if there's any risk being that they're -- it's a general dermatologist, it's not a radiation dermatologist, that there would be any pressure, financial incentive or otherwise, for that dermatologist to -- is there a risk for him to start using it on more and more lesions that maybe, maybe he doesn't know -- maybe just to start overutilizing it?

STEVEN SCOTT: Obviously, that's always a concern. You know, there could be overutilization. That's why the clinical use appropriateness is such a big part of the training we provide. That's why I kind of lead into this segment with, you know, if you went out there to 100 different practices that are doing this, you'll get 100 different flavors of what it looked like.

But what I will say is from what I have seen for the most part, across all of these dermatologists out there, whether they're, you know, practice partners of SkinCure Oncology or not, is you don't really see people doing it just for the money. Honestly, they, they try to do what's best

for their patients overall. You know, that's why we frown on Mohs surgery because if anything was overutilized, it's Mohs surgery. And everybody just gets Mohs surgery because they can.

So we think that there should be a balance, and certainly, you know, I mentioned if we had a practice that we partner with that was sort of off the reservation, if we saw them sending every single patient to just radiation, I mean, that would give us pause, right? Because it really ought to be a solid 50/50 mix. It should be the patient's choice, not the doctor's. They should be presented all options and say, okay. Here's what we can do. We can freeze it with nitrogen and it's going to come back. I promise you, every single time. Okay? We can cut it out and, you know, maybe you have a scar and maybe you don't. Maybe you end up with a big flap or some large plastic surgery repair and maybe you don't. And certainly there's are different grades of Mohs surgeons out there. Some are really good; some are not. Or you can have radiation, you know, and here's the information.

In fact, one of the big pushes for this next year is we believe that there should be a law that says that every patient receive an actual informed

consent of all their options, even if it's not something that that practice provides. They should be able to look that patient in the eye and say, here's what we do here, but there are other alternatives as well.

WILLIAM ATHERTON: Thank you.

REBECCA McFADDEN: When you get that law passed, do it for everything. Know all options.

JOSHUA SWINDLE: It should be done for everything. Full informed consent is, unfortunately, not fully completed.

STEVEN SCOTT: Unfortunately, it's not. How we doing on time? We don't want to run them long.

DOUGLASS COOKE: We have about ten minutes.

STEVEN SCOTT: Dr. Yu, do you want to address what was found in the study?

DR. LIO YU: Yeah. So basically, the -- it's a multi-institutional study. It's a retrospective study. We looked at about 3,000 cases and about 1600 patients. And these are Stage 0, 1 and 2 patients. So early in situ, squamous cell carcinoma in situ lesions with full thickness atypia, which is defined by NCCN as something that's suspicious. Not just a very small, superficial lesion. Up to four centimeters in size. Stage T2.

These lesions are treated pretty much uniformly, about 20 fractions. They were given three or four times per week and we analyzed the results. So the control rate was excellent. About 99 percent. 99.3 percent to be exact. And we, we broke it down in the paper of different histologies and we also looked at the safety in terms of RTOG toxicity. So it was overwhelmingly safe and it's overwhelmingly effective.

So this kind of is the proof in the pudding that is protocol and this method, which I knew from years ago that this, this technology is fantastic and it's great for patients to have as an option.

JOSHUA SWINDLE: I think it's important to note that this is -- these patients are all from a place of service dermatology with an authorized user, that is the dermatologist, and the treatment deliveries were accomplished by a Board certified radiation therapist under the supervision of the dermatologist.

So, you know, we do believe that this should be within the hands of dermatologists, as they are the gatekeepers for this particular patient population. And if they're, you know, adequately and appropriately trained and equipped and they have the

support layers in there, there should be no reason for them to have it, to have it for access to their patient population, safely and effectively.

CLARK ELDREDGE: Do you have a definition of adequately trained?

JOSHUA SWINDLE: That's a good question.

STEVEN SCOTT: What's the question?

JOSHUA SWINDLE: What is our definition of adequately trained. We believe our, our physician population is, you know, adequately trained. They receive both the manufacturer training as well as a, you know, pretty extensive clinical on boarding training with our chief medical officer and sometimes Dr. Yu, that goes over a lot of the subjects that we have, you know, put in there. We have access or provide access for the physicians to have ongoing training, whether it be weekly, monthly, annually. So I'd be happy to give you some information if you'd like.

STEVEN SCOTT: I mean, obviously, the training that's happening for the dermatologists is not going to suffice for the literal interpretation in Part X. We all get that, right? But I think that we're all smart enough to realize Part X was written for the control of radiation with a linear accelerator,

which we don't think any dermatologist out there should be running a linear accelerator, you know, just by themselves. That's a way to hurt a lot of patients.

But to your question, you know, how much is a enough training? Well, there's no such thing as enough. They can always benefit from more training. And there's why having medical physicists and having radiation therapists as part of the solution, really helps round out that training for these dermatologists. They can have all they want and more. We're happy to go back in and retrain. We're happy if they want to have the retraining from the manufacturer all over again, although we have to pay for that. We're happy to have the manufacturer come back and train them all over again.

And again, some of the states have actually put into requirements that once they have been named an authorized user, they've got to have, you know, ten or fifteen additional annual hours specific to training, just to make sure that they've kept their skills up to date.

CLARK ELDREDGE: Yeah. I was looking again at the previous notes and there was a mention of one week hands on, you know, clinical type stuff with

a -- and there was another where it was two-and-a-half hour seminar at the annual, annual seminar at the dermatology national conference. And then one day other hospital, you know, other clinical setting training was mentioned in the previous things.

We have had four medical events associated with dermatological cancer treatments. Two -- well, one I know, one was in an oncology center. Two were actually SRT related and the third was electron beam. And I don't remember if that was a dermatological practice or not.

The two dermatological practices, it was wrong site. The physician and -- he had just brought a therapist on board to place him pushing the button. And the therapist asked which mole was it? Which spot on the skin it was? And he picked out the wrong one.

STEVEN SCOTT: Yeah. You know, that does happen. And God bless them, these patients, if they have one, they've got 15. It's not a matter of if, it's just a win. These are going to manifest. And sometimes these patients come in, I mean, they are just absolutely covered in skin cancers. So identifying the wrong one can happen, certainly, you

know, and it has happened with one of our practice partners as well, where they identified the wrong one. And again, it was a case where the patient had just numerous cancers covering them.

You know, you work in radiation oncology long enough, you're going to treat the wrong site. That's just the reality. That's happened in my background as well, in a cancer center, where even though you questioned the physician, this doesn't look to me like it matches the original picture. Are you sure we're in the right spot? Yes, you are. Go. Right? So it does happen, unfortunately.

But we really go the extra mile on the documentation of what happens, so having the physician and the radiation therapist on the front end actually, you know, triangulating the lesion on the skin, using reference moles. Taking photographs of that. The machine actually has a built-in camera as well. But we can take photographs and it gives you an opportunity to look at all of that.

The other thing, too, is the medical physicists, when they tunnel in to do their weekly chart checks, right? It's all done through the cloud. They can see all of those photographs and the ultrasound images as well. And it has happened

one time when one of our physicists logged in and looked at the photograph and said, that looks different to me. That looks like something has changed. What is going on here, right? And they were able to message the RTT through the system and actually perform a lockout until it had been acknowledged and been corrected. And it was actually, the patient had multiple lesions within the same field being treated. So everybody was right in that instance, but it does happen.

The other thing that we, we really pride ourselves on, and we really insist upon is that if we know there has been a misadministration, the practice will report it. If they don't, we will, you know. Misadministrations happen all the time and most don't get reported, sadly.

JAMES FUTCH: What was the other one?

CLARK ELDREDGE: The other one was two months' worth of patients, potentially. Maybe more. Where the machine was operating through -- 30 percent under the rating. So when they thought they were dosing, it was, the therapists were -- the machine was drifting. The therapist would go and reset the baseline on the machine, not knowing that that's what they were doing, and so it kept drifting down.

This was a mobile system. The machine was in the back of a vehicle.

STEVEN SCOTT: Yeah.

CLARK ELDREDGE: And after it -- it was actually captured by the annual calibration. So if the annual calibration had happened even later --

STEVEN SCOTT: Yeah. So that's why we don't wait for an annual. We do daily qA on all the devices. And that's why the physicists can lock them out remotely if they see a drift.

CLARK ELDREDGE: That was amazingly -- the chart, the two-and-a-half months' worth of the daily checks, that paperwork all disappeared.

STEVEN SCOTT: No. That could never happen.

CLARK ELDREDGE: They said they gave it to the doctor.

STEVEN SCOTT: And he ate them.

CLARK ELDREDGE: The doctor, he lost it.

STEVEN SCOTT: Yeah.

CLARK ELDREDGE: That one is waiting for legal.

STEVEN SCOTT: We would never condone somebody covering something -- the other great thing, too, is because it is in the report and verified in the system, they couldn't cover it up if they wanted to. Honestly and truly, it's locked away forever. And

with regard to anybody having access to the actual calibration of the unit, it's only the physicists. So the RTTs do not have access to it. The physicians don't have access to it. They couldn't go in there and start dinking around with the output numbers and if anybody tried, the machine would lock them out.

In addition to that, the manufacturers test the tolerance at about 3.5 percent deviation. And we have them lock it down to 2 percent deviation for us.

CLARK ELDREDGE: Okay. The machine was getting the 3, 3 percent.

STEVEN SCOTT: Yeah.

CLARK ELDREDGE: Why they had a key, I don't know.

STEVEN SCOTT: You know, we see a lot of stuff out there in the industry. And that's, you know, again, that's part of why we created this endeavor because we thought there should be some standardization. Radiation protection is incredibly important, obviously. Patient outcomes matter, you know. And it's just not something you can half ass.

DR. RANDY SCHENKMAN: Well, thank you so much. That was a great presentation. I think we all

learned from this.

JAMES FUTCH: We had a lot of nice questions.

DR. RANDY SCHENKMAN: Yeah.

STEVEN SCOTT: Well, thanks. And certainly, we want to be good partners.

JAMES FUTCH: We appreciate it.

STEVEN SCOTT: As you guys do decide to make changes or updates, if there's anything we can assist with. We actually enjoy doing stuff like that. We would love to help you all with anything you're working on with regard to your regs or anything you might be considering for training in the future. And/or we really pride ourselves on the way that our centers operate. And, you know, field trips are always available. If anybody wants one, even in this weird Covid world, we will, we will figure out and you can come spend a day and see how patients get treated if you would like. Okay?

Well thank you all very much for your time today.

ALL: Thank you.

STEVEN SCOTT: We really appreciate it.

(Applause)

STEVEN SCOTT: We're going to try to get to the airport.

DR. RANDY SCHENKMAN: Well, it's lunch break time everybody.

JAMES FUTCH: Coming back at 1 o'clock?

DR. RANDY SCHENKMAN: Yeah. We're going to come back at 1 o'clock, if that's okay with everybody.

(Proceedings recessed at 11:58 a.m.)

(Proceedings resumed at 1:15 p.m.)

DR. RANDY SCHENKMAN: If it's okay with everybody, we're going to get started. We're going to give them a little more of a chance to set up. So, Clark?

CLARK ELDREDGE: I have -- is there any discussion further to follow up on the SkinCure stuff? Any thoughts folks have?

ADAM WEAVER: How many of those operations do you have in the State of Florida right now, approximately?

CLARK ELDREDGE: For what they have versus what we have, I have 85 registered superficial therapy units. Well, that are -- the one, yeah. And then -- let me look at that number.

ADAM WEAVER: Oh, just a ballpark.

CLARK ELDREDGE: Yeah. There's one Orthovolt still out there and, like, eight Grenz Ray.

ADAM WEAVER: You still have one of the old Orthovolts?

CLARK ELDREDGE: Yeah.

ADAM WEAVER: Wow.

MARK SEDDON: The Census SRT 100s are like a 50 some or 60 some. It's on the website. They've got a very small base, which is what they're using in Florida --

CLARK ELDREDGE: Right.

MARK SEDDON: -- or a variation of what they're using.

ADAM WEAVER: I remember the other the old Orthovolt machines used to be huge. Almost take up a whole room.

CLARK ELDREDGE: 75 SRT 100s.

ADAM WEAVER: The new tube technology makes them smaller.

CLARK ELDREDGE: Now, with the -- again, the difference between how it's regulated as far as potentially an SRT unit could be a brachy, right? It all depends on whether it's -- whether it is a dose of up to a few centimeters by inner cavity, intermural or interstitial or by application of the source in contact with the body surface or very close to the body surface. So it still comes down

to what's definition of close to the body surface.

ADAM WEAVER: Do you have a definition for that?

CLARK ELDREDGE: No, we don't. That's the problem. You know, so if the -- I saw one thing where it said, one of them was talking about being 30 centimeters from the source of the skin. So it's 12 inches. So I'm looking at the machines. I'm not sure how they're that far away.

ADAM WEAVER: That seems far away.

CLARK ELDREDGE: That seems awfully -- but, yeah. Well, they have their own applicator.

MARK SEDDON: They have a cone.

CLARK ELDREDGE: They have a cone you put on the end for shaping and so that puts a little bit space in there.

MARK SEDDON: Yeah.

ADAM WEAVER: How do they get the positions? Do they fix, like, if it's the head, and they must get it pretty darn close to keep the position of the head. You know, these things aren't instantaneously exposed, probably over a couple minutes, I would assume.

CLARK ELDREDGE: So, yeah.

ADAM WEAVER: Yeah.

CLARK ELDREDGE: It's an articulated head.

ADAM WEAVER: They have some kind of jig or something.

GEORGE GILBRIDE: To keep the head from moving.

CLARK ELDREDGE: Yeah. Just lock it in place. You have to sit real still and move the head around and --

ADAM WEAVER: Like a dental --

GEORGE GILBRIDE: Cataracts type of thing maybe.

I had a new dentist and they took x-rays. Handheld x-ray units. Oh, my God. I'm sitting there and I'm thinking, all I kept going was, are you F-ing crazy? I've been in radiology since 1978, I'm thinking, it's like, you know, and, this is nuts. Okay. Enlighten me.

CLARK ELDREDGE: Handheld tubes.

JOHN WILLIAMSON: We had a whole discussion on those.

CLARK ELDRIDGE: Yeah.

GEORGE GILBRIDE: I'm sorry?

CLARK ELDREDGE: They're actually -- um, the FDA, the handheld machines have been through the FDA process.

GEORGE GILBRIDE: Okay.

CLARK ELDREDGE: The operating position is quite protected. They have the scatter shield mounted at the end of it. And so, there's no particular possible risk of the operator if everything is set up right. We're seeing anywhere near regulatory doses. So that's on the good side. They are running it a couple milliseconds. Again, we're talking about ones that are marketed, built specifically for the U.S.

ADAM WEAVER: You're talking dental ones or --

CLARK ELDREDGE: Dental.

ADAM WEAVER: -- or XRS?

CLARK ELDREDGE: Dental. We switched to handheld dental. They are running at 60 to 70kV.

One of the good things, real short peak, of course, is to get a decent image. If they went for any longer they have a hard time --

GEORGE GILBRIDE: 60 kVs, they still have to go through the enamel of the teeth.

CLARK ELDREDGE: No, that's standard. That -- well, actually, we'll talk in a little bit about in my section.

GEORGE GILBRIDE: Okay.

CLARK ELDREDGE: I'll cover something of that. Let's see here. We do require dosimetry for

handheld operators because it's the only way to know if there's something goofy going on, right?

ADAM WEAVER: You're talking handheld dental units. Only dental.

CLARK ELDREDGE: Well, actually, any -- nobody else is supposed to be using a handheld tube.

ADAM WEAVER: Analytical, the XRFs.

CLARK ELDREDGE: Yeah, but XRFs, but in that case, that's true. I should have -- yeah. An XRF, the only case of being of a real risk there is when people will hold the material you're shooting rather than --

ADAM WEAVER: Keeping it in the configuration or the --

CLARK ELDREDGE: Yeah. Using it how they're supposed to use it. They're doing it without training. They had -- I reported this a while back where we had a wife rat out her husband who bought a machine not registering it. He'd been using it for a few years, holding the jewelry in his hand and was having nerve damage to his hands. And so they -- that's -- she was not happy with it.

ADAM WEAVER: So she blamed the nerve damage on radiation damage?

CHANTEL CORBETT: It was.

CLARK ELDREDGE: Yeah, well, I mean, it was. You use it several hundred times a day for three years continuous, the amount of --

GEORGE GILBRIDE: Like the old radiologists when they came out, they were using their hands, they had all sorts of issues and stuff like that. So it's -- stuff like that.

ADAM WEAVER: Check the old fluoro tubes. Get the orientation, remember the old reverse ones, the green ones?

CLARK ELDREDGE: All right.

DR. RANDY SCHENKMAN: I think we're, we're ready.

JOHN WILLIAMSON: I'm going to start off with giving you a little story. In the late summer of 2018, Hardee County asked us, because of citizen allegations, if there was radioactive material in one of their county parks, to do a survey of their park. This was Hardee Lakes Park, which was donated to them by Mosaic, which was one of the largest phosphate mining companies in the world. So we agreed to do a survey. They were particularly concerned about phosphate reject rock, which is rock that is not of quality enough to go through the phosphate extraction process.

So we went through with our Radiation Solutions mobile radiation detection system. We drove every single road in the park. We also went in all in the areas where there was campsites. We went in the off-road areas. We made an analysis of what we found.

And on the roads, typically we're finding exposures of about -- sorry, I know you guys are medical. I'm used to dealing with English -- about 15 microR per hour. We found some areas as high as 36 microR per hour. These are compared to normal backgrounds of 6 to 10 microR per hour.

So we wrote a letter to the Hardee County manager, that based on NCRP 116, which is the exposure the public to naturally occurring radioactive material, we didn't believe that the minor amount of time that most people spend at a county park was going to accumulate more than 100 milligram a year of dose, which is the criteria for NCRP 116. If it's a 100 milligram or more above the normal background, you might consider doing something about it. Our calculations were that somebody who stayed there on the order of 30 days a year will get, I think, 10 to 15 milligram of additional exposure.

Anyhow, so that was all 2018. Earlier this summer, I got an inquiry from two reporters working on a documentary from CNN, who were interested in the work that we had done. They disagree with the methodology and the conclusions that we came to on that particular park. They asked to do interviews with -- the Department doesn't typically allow any of that type to take place.

At some point, I expect in the next couple months, there will be a documentary on this. And I just thought you guys deserve to at least hear about it before you see it. Since you're on the Advisory Council, it will be nice that somebody told you that hey, by the way, you might see something.

If you have any questions, I'll be happy to answer it. Afterwards will probably be better because we're a little short on time here.

So the next thing I want to talk about is the instrument, the equipment updates that we've taken for the Bureau. This is an R200. It's actually a spectroscopic personal radiation detector. But in essence, what it really is is a RID, relay isotopic identifier, that tells you what gamma isotope you're dealing with. The current method by which we respond to radiation incidents is we receive a call

from our duty officer in Orlando. He calls a regional duty officer who typically goes out and makes the response. If the response looks like it's going to need isotope identification, that duty officer has to drive to the storage shed maintained by each of those regional locations, which could be, you know, in Miami traffic, could take you two hours to get to the storage shed, which obviously, means that the amount of time that it takes us to respond to a radiation incident could be a significant amount of time.

So what we've decided to do, we bought one of these for each one of the regional duty officers, so when they're on call, they will have this with them all the time. So they don't have to drive to the storage shed to pick up the RID. This gives us probably only about 70 percent of the total capacity because the RID they have in the storage shed is a much larger detector. This is a much smaller detector. But for most of what we do, it's more than adequate. So we're cutting down the amount of time that we're going to spend taking to respond to radiation incidents.

And it turns out, if we get there with this, they can actually capture a spectra. All of these

inspectors, for the most part, have smart phones. They can actually connect to this device with their smart phone and they can send that spectra off to us and we can send it to the Department of Energy to actually have reach back concern. In that same time, they can get another person from the office who can go to the storage shed, pick up the more advanced RID and bring it back so they can do an additional spectrum on it.

JOSEPH DANEK: What's is that unit called? I'm sorry.

JOHN WILLIAMSON: It's an R200. It's actually a spectroscopic personal radiation detector. But in essence, it's a RID. It just has a very, very small, I think a click. A cesium --

ADAM WEAVER: Cesium iodine?

JOHN WILLIAMSON: No, it's not a cesium iodine. It's just a click. It's the cesium, atrium, lutecium --

ADAM WEAVER: Oh, yeah.

JOHN WILLIAMSON: It's one of those composite crystals that they use. About the, about the same resolution as a sodium iodine.

We've also, we do a lot of PRD, preventive rad nuke detection. We talked about that in the past,

monitoring the Super Bowl, of the Daytona 500. We do a lot of that, carrying backpacks with large radiation detectors on our back. Previously, the ten backpacks we had only would tell you what the radiation dose rate was. It wouldn't tell you what the isotope is.

Over the last year, we purchased two of these backpacks from Radiation Solutions, Incorporated, a company in Canada. Same company that make our mobile radiation detection systems. This one has two cesium -- no, two sodium iodine detectors and a neutron detector. So these actually will give us an ID as well as telling us what the gamma dose rate is.

So where you see an instance for using this, if you're -- for instance, we did monitoring at the Fort Lauderdale International Boat Show at the end of October and we -- they have, I think, seven or eight separate gates. So we put one of these at the gate with one of our personnel. When somebody comes through, normally, it would've been that would set off an alarm. We'd have to get our RID. We'd have to go stop them, ask them to hold and we'd do a five-minute count before we'd be able to ID.

These, because of the size of the detectors,

they're three-inch sodium iodine detectors, they can actually give us an ID usually just by somebody walking by. They had, I think, about 15 alarms. All of them happened to be medical alarms. This one will ID in a very, very short amount of time. So it means you don't have to go catch the person, unless it shows up as a -- one of the things, for instance, if somebody goes by and it's medical, we're not concerned about. If somebody goes by and it's cesium, we start to get a little more upset. If somebody goes by and you get a neutron alarm, then you start thinking, you know, possible nuclear weapons.

So anyhow, so what I've done is I brought a number of different check sources. I think six different gamma isotopes. So you are welcome to come up and actually take ahold of the instrument and take a look at what -- how they operate. And we can also bring stuff by this one. You can see what the gamma ID is.

This one is nice because it actually reports the data. You can link up a phone to it. You can simply act like all the other millennial generation and walk around with your nose in the phone instead of paying attention to anything else and nobody will

think anything different.

JOSEPH DANEK: So come up and do it?

JOHN WILLIAMSON: Yeah, sure.

ADAM WEAVER: You're the environmental guy. You're supposed to do it.

JAMES FUTCH: You have a question? Giovanna has got a question.

GIOVANNA MANNING: I want to know, that's an app that --

JOHN WILLIAMSON: Yes.

GIOVANNA MANNING: -- the Bureau made, we made it?

JOHN WILLIAMSON: No. It's made by the company, the manufacturer.

ADAM WEAVER: No, from the vendor.

GIOVANNA MANNING: Okay. The vendor.

JAMES FUTCH: It is available to put on your phone and it's even approved by the Department.

JOHN WILLIAMSON: Yes. We went through all the rigmarole to get it approved by the Department.

ADAM WEAVER: Does this actually show you a spectrum?

JOHN WILLIAMSON: Yes, it does. And you can actually do it on your phone as well, but I didn't bring a phone for it.

CHANTEL CORBETT: Do you know what the price tag is on the R200?

JOHN WILLIAMSON: Which one?

CHANTEL CORBETT: R200.

DR. NICHOLAS PLAXTON: Twenty bucks.

JOHN WILLIAMSON: $3800 with the neutron detector.

DR. NICHOLAS PLAXTON: Which one? That one?

JOHN WILLIAMSON: No. This one.

MARK SEDDON: No, this one.

DR. NICHOLAS PLAXTON: How much is that one?

JOHN WILLIAMSON: $31,500.

MARK SEDDON: Yeah, I was going to say.

CHANTEL CORBETT: I was like probably add another zero on that. Yeah, the other RIDs are much bigger.

DOUGLASS COOKE: I thought my kid's backpack was expensive.

JOHN WILLIAMSON: And then this one, the middle button on there, that means --

JAMES FUTCH: So the one on the right has a super tiny screen. You better know what button does what before you touch it.

JOHN WILLIAMSON: Yeah, it's definitely meant for the younger --

ADAM WEAVER: Can you link it to your phone? Will it bluetooth to the phone and make the screen bigger?

JOHN WILLIAMSON: You can't get the exact display on your phone. You can get a, you can get a count rate. And then you can download stuff to it. But it's not as friendly as it should be.

GIOVANNA MANNING: The R200 does not have an app?

JOHN WILLIAMSON: Yeah, the R200 has an app as well. It's not a mirror image. It doesn't show you exactly what the screen does.

(Off-the-Record Review of Equipment Updates)

DR. RANDY SCHENKMAN: Thank you so much. John, thank you so much for your presentation. That was great.

JOHN WILLIAMSON: You're welcome.

ADAM WEAVER: Thank you, John. Nice toys.

(Applause)

DR. NICHOLAS PLAXTON: I feel safer now.

ADAM WEAVER: I can go to the next Super Bowl and feel --

CHANTEL CORBETT: That was what was holding you back.

ADAM WEAVER: That was what was holding me

back.

CHANTEL CORBETT: Not the ticket price.

DR. NICHOLAS PLAXTON: Yeah, right?

ADAM WEAVER: No, no, no. It was fear. The last one was in Tampa. It was the first time a home team -- This year it's in Los Angeles.

DR. RANDY SCHENKMAN: Okay. Do you want to go next? Clark, do you have more you want to do?

CLARK ELDREDGE: No, I'm good. Until my turn.

JAMES FUTCH: All right.

DR. RANDY SCHENKMAN: Wait. Should we have Douglass go first?

JAMES FUTCH: You're up, Douglass.

DOUGLASS COOKE: Good afternoon, everybody. If I can direct you all to the last three pages of the package you have in front of you. Again, since I am the replacement Brenda today, I will be handling her task of trying to set up our next meeting.

Yes, sir?

CLARK ELDREDGE: You asked me if I had more stuff to cover from my group?

JAMES FUTCH: No.

CLARK ELDREDGE: We're doing that --

DOUGLASS COOKE: Because I have to drive to the -- yeah. So availability is March, April and May.

If anybody has the time that they're --

DR. RANDY SCHENKMAN: April or May would be better for me.

DOUGLASS COOKE: Okay. So Dr. Schenkman has requested we skip March, so we'll just go to April or May. And we're waiting on an update about a --

ADAM WEAVER: There's a Florida Health Physics Society meeting.

DOUGLASS COOKE: That's important too, yes.

JOSEPH DANEK: That's supposed to be April 7th.

ADAM WEAVER: Okay.

CHANTEL CORBETT: On a Thursday?

ADAM WEAVER: It starts Thursday and the meeting is on Friday.

DOUGLASS COOKE: So we'll skip past the first week of April. You can all think about me that day since it's my birthday while you're there. Thank you.

ADAM WEAVER: When's your birthday?

DOUGLASS COOKE: April 6th.

ADAM WEAVER: Mine's the 7th.

GEORGE GILBRIDE: Mine's the 8th.

DR. RANDY SCHENKMAN: Look what I started here.

(Laughter)

DOUGLASS COOKE: That's puts us in the second,

third or fourth week of April or any time in May. Does anybody else have anything going on or --

GEORGE GILBRIDE: Easter's our anniversary, but that's fine.

DOUGLASS COOKE: So schedule it for the 23rd. Yes, sir. Gotcha.

JAMES FUTCH: So may has --

CHANTEL CORBETT: I'd April 21st or --

DOUGLASS COOKE: Yeah, I was going to say --

ADAM WEAVER: Or the 28th.

REBECCA McFADDEN: The 28th looks better.

JAMES FUTCH: How about Tuesdays or Thursdays? There used to be a big dichotomy between Thursdays and Tuesdays.

WILLIAM ATHERTON: I like Thursday. John?

JOSEPH DANEK: The last week of April is bad for me. Last week of April.

DOUGLASS COOKE: Last week of April is bad for you? How about the 21st? That's a Thursday. Is everybody okay with the Thursdays?

DR. NICHOLAS PLAXTON: I can't make the 21st.

DOUGLASS COOKE: Okay. Let's go to May people.

DR. RANDY SCHENKMAN: Are Tuesdays good for --

DOUGLASS COOKE: Tuesdays better?

REBECCA McFADDEN: The 12th or the 19th.

ADAM WEAVER: April 19th.

JOSEPH DANEK: Tuesday the 19th.

DR. RANDY SCHENKMAN: Is Tuesday the 19th good for everybody?

CHANTEL CORBETT: Okay.

GEORGE GILBRIDE: April?

JAMES FUTCH: It's two days after Easter.

GIOVANNA MANNING: I hope it's good for Kevin.

ADAM WEAVER: Once you come, you've got to keep coming.

DOUGLASS COOKE: Yeah. Listen, I tried to get out. I wasn't here for, like, three times and they drug me back in. So we're going to go April 19th?

DR. RANDY SCHENKMAN: So we're going to do Tuesday, April 19th for our next meeting. Okay?

CHANTEL CORBETT: That sounds good.

GEORGE GILBRIDE: Put that in my phone.

DR. NICHOLAS PLAXTON: Same place?

DOUGLASS COOKE: It will be in this area. Hopefully we'll try to get this hotel again. Obviously, Hilton owns all three of them. So it will be at one of these three.

DR. NICHOLAS PLAXTON: Okay. Got it.

DOUGLASS COOKE: I kind of enjoyed the breakfast this morning, so I'll put --

DR. NICHOLAS PLAXTON: I missed it. It ended at 9. I was hoping, I was planning on it. They always have a free breakfast. Usually they go to 10.

DR. RANDY SCHENKMAN: Are there any other updates for you?

DOUGLASS COOKE: I did not have any other -- oh, yes. Your, your travel is all still pending. There was a kerfuffle. That will be a good word for today. Kerfuffle.

GEORGE GILBRIDE: Watch your language, young man.

DOUGLASS COOKE: Yes, I will try. Next meeting, I will. So basically, what's going to occur is we'll get everything put together and sent out to you all for signatures. It should be, if not tomorrow, it will be the first part of next week. I know Brenda's back in the office on Monday, so you probably don't expect it before then. And we'll just make sure everything gets taken care of with one, one transaction.

DR. RANDY SCHENKMAN: E-mailing it to everybody or mailing?

DOUGLASS COOKE: It will be e-mailed just for your signatures and then we can print and scan and

everything. I'll take care of the rest of it. But, yes. Apologies there. Because usually we just have you sign two copies and we take it back with us but that was unable to be done this time. So we'll take care of it as soon as possible and get you all reimbursed as quickly as possible.

DR. RANDY SCHENKMAN: Okay.

DOUGLASS COOKE: Anything else for me? No?

DR. RANDY SCHENKMAN: So, Clark, do you want to finish?

JAMES FUTCH: Then go on to your stuff.

CLARK ELDREDGE: Okay. Go ahead with mine? Okay. So then we have just the radiation machine updating section. All right?

The machine update. We've just -- well, we're not finished with the annual renewals, but we're through with the people who bothered to register on time. We're currently 85 percent of all the registrations, 19,500 or so. Eighty-five percent of them have submitted their money and have been issued their registrations. Things actually went pretty well this registration period, even though we had one of our staff quit at the very beginning.

GIOVANNA MANNING: So that's why I was doing so much work.

CLARK ELDREDGE: And Miss Manning gets kudos for the boxes of -- for the trays and trays of checks and payments she approved for processing. So she's a huge help for us.

So we're down to, yeah, fifty to a hundred renewals as they trickle in a day. And we'll be sending out our second notices in a couple weeks. We usually send out second notices around 15 -- 10 to 15 percent left, so we're about that point right now.

Medical quality -- excuse me, Mammography Quality Standards Act. MQSA. We're in the fourth year of our five-year contract.

We currently have 617 ACR accredited mammography facilities in the state; five provisional, although this year, we're contracted to do 671 inspections for this year. Part of that is to make up for the pandemic shut down. So we're, you know, so the folks that were being inspected -- MQSA requires people to be inspected between 10 and 14 months. MQSA, between 10 and 14 months from the last inspection. Ideally, you're trying to hit the 12-month mark, one year.

So with the 671 inspections, those folks that were inspected at the beginning of our contract year

will see us closer to ten months. Ten to eleven months to get, to be able to get our full 671. Part of the reason they've done that is to not only make sure we catch up and get everything back on track, but make sure we're not out of contract money they're providing us to perform the inspections.

They are also proposing that they're going to realign all the contracts so they all end on the same day. Things tend to creep and out of sight.

(William Atherton Leaves the Meeting)

CLARK ELDREDGE: So they're going to -- currently, our contract is September 1st to August 31st.

(Dr. Randy Schenkman Leaves the Meeting)

CLARK ELDREDGE: And they're looking at putting all the states on either a June 30th cycle or potentially an April, April cycle, but people are hopefully going to do the June 30th because that aligns with most states' budgets when you do it that way.

We are currently the second largest program in the U.S. Second largest number of facilities. And we're still -- we're short currently one inspector. We were down about three qualified inspectors. We were able to get two through the last training. One

retired and came back, so we're in pretty good shape.

We have two inspectors who left their inspector position. They're supervisors, so they're filling in until we get full -- enough inspectors that are qualified for that.

Medical events, we've had two since last meeting. We have -- one was a rather difficult pancreatic treatment with a lot of soft tissue. They had trouble get all the markers aligned as they prepped the thing. So that was a wrong site. The other one was just reported just before Thanksgiving, and so I don't know the details on that one yet. I haven't seen the facilities report.

Enforcement investigations going on for us, DEXA sales and referrals. Companies that are out of state selling health coaching services and, you know, getting you in shape and referring you to in-state DEXA providers to get you DEXA scans to see how you're progressing on your exercise regimen.

ADAM WEAVER: Someone else to yell at you.

CLARK ELDREDGE: So we're currently -- of the various DEXA folks that were on the list, from the -- for referrals, most of them were folks that we've already been working on because they are also

selling it as DEXA scans as part of the personal weight loss, personal body, whatever type.

GEORGE GILBRIDE: Body fat.

CLARK ELDREDGE: Yeah. These are all about body fat measurements rather than bone density. But they actually have licensed practitioners in the office. They work with -- we've gone with them to make sure that they are following proper -- our legal requirements because there's no such thing as a non-medical x-ray in Florida other than the limited security allowances in the, in the jails for prisoners. So that's -- everybody else is medical. There has to be a physician who authorizes it; who's using it as part of your health care treatment in our statutes.

So, you know, so this one place, one of the people we worked with actually goes and they don't give you the result right then when you walk in. They actually, it has to go to the physician's staff office to review it and whatever recommendations they give, you know. Normal kind of medical review of the report and provide back.

And so, the one that -- the two that were most interesting are in this group of -- one is a hospital who didn't seem to know that there should

be a doctor authorizing these x-rays.

GAIL CURRY: Hmm.

CLARK ELDREDGE: And the other one was a gym in the Tampa area, which apparently doesn't have the machine, but they were on their site. So that was interesting that they were having a, a gym listed but --

GEORGE GILBRIDE: Was it a mobile?

CLARK ELDREDGE: No. We don't know the details. Just -- we have -- we're pursuing more cases where facilities are selling subscriptions to full-body CTs. Come get your annual full-body CT. We'll give it to you and then we'll send the results to your primary care and we're not going to do a thing with it. Yes, we'll send it to radiologists but we're not going to follow you up with it.

DR. NICHOLAS PLAXTON: That's messed up.

CLARK ELDREDGE: And so, we had -- a couple years ago, we had a facility in this area who was looking to buy their own machine to do this. Right now, we've got one group in town right now that's selling them, but they're referring people to diagnostic centers, which is a little bit more about our ability to enforce that. Since the person owning the machine, it looks to them like it's part

of the normal medical system. This other group purchased their own machine and currently that's over in legal and when they applied.

And unfortunately, I found there are two more facilities in Florida which were not recognized that's what they were doing and they currently have registrations. So we have to go back and work back with them to find out how they're complying with 44.22 paragraph 8. I think it's 8, not 7, which says, again, the doctor's got to be involved with it. He's got to order your x-ray and provide you with medical care through the results of that x-ray.

We continue to find more of the non-FDA compliant handheld dental units. This was a -- now, the last two were veterinary units, were in veterinary practices, which don't have to meet the same standards for human exposure, but they have to meet the standards for operator safety. And they don't meet the standards for operator safety. So, you know.

We are working on some draft language for rules, as always. One of the other recent things we've had is with the industrial -- mobile industrial radiography rooms. People want to claim they're cabinets, but we're talking something that's

ten by ten or larger. People walk in, they dump stuff in there, they walk out and close the door. Our codes require them to be industrial radiographers to operate these systems. And of course, the people who register them think they're only cabinet machines and don't require the appropriate training for their employees to operate the machines.

And our language in our statute doesn't -- in our rules, doesn't quite clearly draw the line between the cabinet and something you could walk in. Because the actual machine website, the manufacturer in this case is Nikon. Their thing doesn't describe it as a cabinet as all. The register is calling it a cabinet. And they call it a walk-in x-ray room. A radiography room is what they call it.

But then we have other -- but then again, you look at some other sites selling these -- this type of equipment. They call it a walk-in cabinet, so --

One thing that we can use help with, if anybody on the committee has any insight, references, resources, with our statutory updates, trying to re-envision the registration scheme and standard. Currently, of course, the registration is linked primarily to who's operating the machine and not the

hazard.

I had written language that was -- and submitted it up to try to change it from is it a doctor, is it a vet, is it an educational facility, to is a human being put into the useful beam or not. Or is an accelerator. That's specified in there. I think that's fine to differentiate accelerators in that way. Or -- and then with the techs versus the doctors, the question becomes, yes, you have somebody being put in a useful beam, but what's the actual dose rate from the machine, what's the potential of the tube; things like that. Originally, you're looking at the potential for the tube, but that doesn't work out so well because while dental units are working at 70kV, you have mammo at 30kV, and you have extremity CTs that are working down at 50kV. And those things are putting a lot more dose through the person than dental is. So -- and that's sort of, if you look at the history and you look, of course, all regs are based in the 1980s.

That was a good proxy, who was operating the machine was a good proxy for the machine and the risks involved. All the dental podiatry were only, you know, they didn't have CTs in their practices.

So as usage of machines have changed, I'm trying to propose language. It was rejected last time we put it through, just because it also involves language that affects the fee structure. Because the fee structure, itself, is tied to who's operating the machine. And now they want to tie the fee structure to the risk from the tube to the person and the operators.

Not that we want the fee structure to change any. We just need to reword it to reflect it and that's what killed it before. But if anybody has any good way to reference resources they feel would be useful for trying to find the right language to split between the dental podiatry section and the rest of the medical, it would be useful.

I've been trying to research things, reference documents from ACR, from IAEA, from many of the other reference exposure studies and things like that, to figure if there was some good value to park there, and it's not really clear when you look at these things. There's rather large bands and things like that, so we're trying to find a good measure to be able to make that break point between the five-year inspection cycle between the very simple podiatry, dental-type operations versus things that

take a bit more work to maintain and keep calibrating and things like that.

So again, anything you all have, any resources or something you all can think of or come up with, please let us know. Let me know so I can look at it and bring you all back something to --

MARK SEDDON: I know we debate this every time we try to register a new facility. What category does this fall underneath? It's always 370AD. What's that exactly?

CLARK ELDREDGE: And that's the other thing. We do need to expand the registration categories more because the free-standing emergency rooms and those things, we don't -- that, now fortunately, that's a rule thing rather than, you know, and the fees will still be the same. But we do need to add more categories for the surgery centers and the, the emergency room, urgent care facilities. Because they're not hospitals and they're not doctors' offices. And that's the -- that was the choice to flip the coin on. So --

MARK SEDDON: So talk to them about it.

CLARK ELDREDGE: Yeah, we definitely -- I would appreciate your insight on it. We definitely need to talk about it. All right. I think that covers

everything I had on my list. Any questions, any inspiration?

ADAM WEAVER: Just, I talked to you about the -- when people are using lead aprons. Your draft.

CLARK ELDREDGE: So I do have to talk about that now and I want to know if you all agree to endorse it. Do we have the form still?

CINDY BECKER: We do.

CLARK ELDREDGE: So the -- do we all have copies of the latest drafts?

ADAM WEAVER: You e-mailed them to us.

CLARK ELDREDGE: Everybody, if you can take a look at them.

JAMES FUTCH: Clark, I can pull them up if you want to.

CLARK ELDREDGE: Yeah, why don't we pull them up. That would be easier.

JOSEPH DANEK: I've got a couple comments on it, too. The dose weighting factor as well as the apron.

ADAM WEAVER: You probably have the same comment I do.

JOSEPH DANEK: We'll see. Oh, no, mine is different.

ADAM WEAVER: Is what?

JOSEPH DANEK: Yours is the gonad or apron? Same thing as apron? Dose weighting factor.

ADAM WEAVER: Yeah. Well, it's not appropriate for x-rays.

CHANTEL CORBETT: Right. They ruled that out in the last one.

ADAM WEAVER: Yeah. Alternate double T's.

JOSEPH DANEK: What's gone?

CHANTEL CORBETT: Gonads.

JOSEPH DANEK: You can't use them any more?

CHANTEL CORBETT: You can but it's not recommended.

JOSEPH DANEK: This thing is going to come out?

ADAM WEAVER: Well, it's just a draft right now.

JAMES FUTCH: Which one do you want?

ADAM WEAVER: The dose weighting factor is first for me. Joe did an internal dosimetry --

JOSEPH DANEK: Yeah, that's the one.

JAMES FUTCH: Clark, which one is that in?

ADAM WEAVER: It's number four.

CLARK ELDREDGE: Number four.

ADAM WEAVER: Information notice number four.

CLARK ELDREDGE: Yeah. Because that's the revision. Information number four was originally released, basically specifying the calculation and the appropriate -- that we didn't really have the authority in that, so it was withdrawn and never really updated. So even though everybody was kind of still following it, because there really aren't that many peer-reviewed approved methods for adjusting, correcting or weighting the dose for using aprons.

ADAM WEAVER: But there's probably 40 different methods. Actually, I have 11 right here on the paper.

CLARK ELDREDGE: Wow. I had not seen all those.

ADAM WEAVER: Yeah. This was published -- I don't know what date. I didn't put the publish date. But I guess my main concern with, do we have to use WT? Because all you're modifying is the effective dose equivalent. And you're just using a correction factor. Whatever's appropriate for your site, whether you're using one badge at the collar or wearing two badges. One at the collar, one at the mid section under the apron.

CLARK ELDREDGE: Right.

ADAM WEAVER: So, you know, and it depends, you know. There's so many different variables. What's the thickness of your apron? Is everybody wearing the same thickness? It may be true; may not. Some doctors buy their own aprons because it may be more comfortable for them to have a two-piece one versus a single piece. There's all kind of -- there's so many variations. And then there's a complete wrap around, so there's so much -- but I just -- I don't -- you know, doing a lot of internal dosimetry, the weighting factors, really, only applied for internal dose.

CHANTEL CORBETT: So more of a correction factor.

ADAM WEAVER: Yeah. It should be just called a correction factor.

CHANTEL CORBETT: Yeah.

ADAM WEAVER: And Landauer calls theirs --

CHANTEL CORBETT: A correction.

ADAM WEAVER: -- just a correction. They don't even put factor. They just put correction. You know, they have the two methods. The ED1, which you can select, or the EB2. Again, it's only for x-rays, scattered x-rays, you know, when people are taking care of patients. Whether it's a doctor or

his or her assistant. That's it, you know, be close enough to the patient, or maybe on the other side of the patient because you get a lot of scatter.

CHANTEL CORBETT: Yeah.

ADAM WEAVER: And these lead aprons only do good or offer any protection factor if you're wearing them properly and only if it's scattered x-rays, not --

CHANTEL CORBETT: Correct.

ADAM WEAVER: -- nothing to do with the primary beam or -- and let's face it, most x-ray tubes don't have much leakage nowadays based on their design. So I was hoping we could change it to correction or correction factor.

CLARK ELDREDGE: All right.

CHANTEL CORBETT: Second.

ADAM WEAVER: Huh?

CHANTEL CORBETT: I second that.

ADAM WEAVER: If you want, I can give you the reference for the 11 different methods.

CLARK ELDREDGE: Yeah. I'd like to have that anyway, but I won't need it for this. But, yes, I would appreciate that. We'll need to include that.

ADAM WEAVER: I was amazed when I found it. I mean there's table one, algorithms for calculations

of effective dose.

CLARK ELDREDGE: All right.

ADAM WEAVER: So I don't forget to give it to you, I'll give it to you now.

CLARK ELDRIDGE: So I'll work through replacing alternative WT with the correction to, you know, a correction to -- you all can chime in, too.

ADAM WEAVER: Because, you know, there's an NRC regulatory guide on this issue. 8.4.

CLARK ELDREDGE: No, I didn't know that.

ADAM WEAVER: Methods for measuring effective dose equivalent from external exposure. It was published, I guess, July 2010. I don't believe there's any update. And there's an NCRP on this. I believe there's an ICRP on it.

CLARK ELDREDGE: A correction to the effective dose. Dose may be adopted under this scenario. So at the beginning -- and I can follow through from there. Where it says, second paragraph, an alternative WT may be adopted, I can say a correction to the effective dose may be adopted under this scenario.

ADAM WEAVER: Maybe you add wording in there that you want it to be approved before you actually used it or, or you can't really use it after the

fact. Isn't that -- wasn't that one of your objectives?

CLARK ELDREDGE: Well, one of -- well, you can't -- for facilities that find they're in trouble and they're trying to say, oh, well, yes, we were having bad practices, we're just going to put a correction backwards on this exposure, that we don't particularly want to allow when people are adopting it after they've gotten in trouble.

ADAM WEAVER: I mean, most of these facilities are going to know.

JAMES FUTCH: Paragraph D. Paragraph D.

CHANTEL CORBETT: Right. That's kind of what we said last meeting was the fact the majority of, like hospitals especially, have been using correction factors forever and ever, but they to find approval letter, like, that's not going to happen.

CLARK ELDREDGE: Yeah. We're not -- that's not a big concern on our part.

CHANTEL CORBETT: Yeah.

CLARK ELDREDGE: We do want to make sure we get it all caught up and updated and corrected but that will take a couple years.

CHANTEL CORBETT: Right.

CLARK ELDREDGE: It will be certainly nothing that involves any sort of enforcement action. It will just be, hey, we need to get these things updated.

CHANTEL CORBETT: Right.

CLARK ELDREDGE: It's like we need RPPs from everybody and we're still -- I've been going through files and there's people supposed to file their, submit RPPs to us when they're not using the standard RPPs, and we hardly have any of them out there.

CHANTEL CORBETT: Right.

CLARK ELDREDGE: It's just cleaning it up.

JOSEPH DANEK: Are you done, Adam.

ADAM WEAVER: I'm done. I've had enough.

JOSEPH DANEK: My turn. I have a few comments I've got.

JAMES FUTCH: Same one or different one?

JOSEPH DANEK: Same one. No, it's the same one. Yeah, yeah. The rules are 64 E to the minus 5 decimal point 101. Right on the top there. If you go to the very top. It didn't identify the rules properly. 64E to the minus five point 101. Right?

ADAM WEAVER: Yeah. Those are the definitions.

The definitions. 29 would be -- I believe we've --

JOSEPH DANEK: I know that 2943. Instead of 161. I think it's supposed to be 159.

ADAM WEAVER: I don't have the definitions.

JOSEPH DANEK: I went through 64E minus 5 point 101.

ADAM WEAVER: Point 101 of the definitions?

JAMES FUTCH: I think, did we miss the dash five?

JOSEPH DANEK: Yeah. That's what I'm getting at.

ADAM WEAVER: Yeah, I think we did. Yeah, you left the dash 5 off.

GEORGE GILBRIDE: If you say something about differentials, I'm leaving.

JAMES FUTCH: I'm sitting here trying to figure out -- who the hell cares about to the negative 101.

ADAM WEAVER: Good pick up, Joe. I didn't even pick up on that one.

JAMES FUTCH: It's pretty small.

JOSEPH DANEK: Yeah. And I'm pretty sure 161 should be 159 for weighting factor. Associated with the weighting factor.

CLARK ELDREDGE: Yep, you know, you're right. That's a typo.

ADAM WEAVER: It shouldn't be used here.

JOSEPH DANEK: Unless you want to talk about [inaudible].

CLARK ELDRIDGE: No, no. Although that has its own interests, it's not --

JOSEPH DANEK: Probably. And then this is just an editorial. But C-2, standard setting body, standard setting body or a national or international. You have A-N there. It's in C-2.

JAMES FUTCH: Over here (indicating)?

JOSEPH DANEK: Yeah, right there.

My only other comment, I don't know if you want to put that in there, in the information notes. Maybe not. I'm just bringing it up. Is something about the dose records will be reviewed by the state during inspections. I don’t know if you want to put that in there or not. But inspect. Hopefully the inspectors will come in and look at the dose records when they apply these. Well, they're not waiting factors. When they alter the dose, that they're going to review them to make sure they properly did it. So I don't know how -- if that should be [inaudible]

ADAM WEAVER: Well, usually these facilities are going to use a commercial company to supply

their dosimeters. They're not going to do it on their own.

JOSEPH DANEK: Oh, they're not going to do it? Oh.

ADAM WEAVER: So they're going to -- they're going to tell the dosimeter company, these peoples' badges, you should write -- use this correction factor for because they're wearing aprons all the time.

JOSEPH DANEK: Okay.

CHANTEL CORBETT: The down side of that is like Landauer can say sometimes that the correction is there.

ADAM WEAVER: Yeah. Landauer will tell you the before and then the corrected value.

CHANTEL CORBETT: Yeah. Then you have some problems with it later.

JOSEPH DANEK: So it's a little different animal. Coming from the nuclear power plants when we do --

ADAM WEAVER: Where you guys had your own dosimetry program.

JOSEPH DANEK: Multiple badging and assigning dose, we had to do it correctly.

ADAM WEAVER: Right.

JOSEPH DANEK: It does get inspected. This is

a different animal. But that's my only comments.

ADAM WEAVER: Yeah. You guys probably had your own TLD program.

JOSEPH DANEK: We did, but we did a lot of multi-badging and assigned the dose. We used correction factors.

ADAM WEAVER: I guess, has anybody tried doing this with electronic dosimetry yet? I don't know if anybody is doing that yet. Eventually that will come up.

MARK SEDDON: Yeah, you would think, because most people using electronic dosimeters are using it in a fluoro environment. High exposures. We're not using ours at our facilities.

CHANTEL CORBETT: I think Sarasota Memorial was looking into trying it. I'm not sure that they have yet. I can check.

MARK SEDDON: I know Orlando Health is using them, but I don't know if they're applying weighting factors or not to them.

ADAM WEAVER: It would be interesting. For all we know, they could be self-correcting.

CHANTEL CORBETT: Whether it's going to be a live correction or --

ADAM WEAVER: Yeah. Maybe it's built into

the --

CHANTEL CORBETT: Right. Can I ask you a question?

ADAM WEAVER: Interesting. Not something to worry about yet, but, until we do it. Luckily, I don't have a pain management guy anymore.

CLARK ELDREDGE: Okay. So, we'll go through and adjust weighting, the WTL alternative weighting factors and stuff to a dose correction factor and make adjustments to the language.

So, what I'm trying to say are to be correct or, you know, where tenses need to be corrected and word agreement and stuff like that. So correct grammar to match that. So that, the corrections and the fact that 161 as supposed to 159.

ADAM WEAVER: And add the dash five.

CHANTEL CORBETT: I think you've got the dash. You need the five and the period.

JAMES FUTCH: That's what I was saying. Do we have a 101? I'm sure we have a 101.

CLARK ELDREDGE: Oh. You know, it's amazing how when you know what it says, you can never read it.

CHANTEL CORBETT: Oh, yeah, your mind fills it in.

REBECCA McFADDEN: Your mind, yeah, fills it in.

ADAM WEAVER: It just skips over that 4-5. It's because you need to use four. What's the other one?

JAMES FUTCH: Are we done with this one?

CLARK ELDREDGE: Are we're done with this one? So would you all accept everything with that -- you all --

MARK SEDDON: Other than what we talked about the whole summing dose for people who are badged with weighting factors, do you want to say anything to that? A statement that they can, some cumulative annual exposure across multiple facilities, some use weighting factors; some don't.

CLARK ELDREDGE: I mean, summing across the facilities is already in the code, but you're right.

MARK SEDDON: Should we clarify that or not?

CLARK ELDREDGE: Should we clarify it?

ADAM WEAVER: Was it covered in this one?

CLARK ELDREDGE: Was it used in one and one not?

CHANTEL CORBETT: Than what?

MARK SEDDON: For example, like say a physician who works at two facilities, one facility is using a

weighting factor, one facility doesn't.

CHANTEL CORBETT: Right.

MARK SEDDON: You know, when you're summarizing for the maximum permissible, can you utilize -- how do you do that?

CHANTEL CORBETT: That's what I'm saying. Do you want to say the correction factor --

MARK SEDDON: The corrected dose is used for -- do you need --

CHANTEL CORBETT: Across the board?

MARK SEDDON: Yeah. Well, no, not across the board. Should that be used in summing it with the -- you're not equal, I guess what I'm trying to say.

CHANTEL CORBETT: Yeah.

MARK SEDDON: So, should we clarify that?

CHANTEL CORBETT: Well, I mean, it's hard not to get those actual doses at one facility. As much as you try to get three facilities to agree. But, yeah. I don't know that --

ADAM WEAVER: It's hard to imagine.

CHANTEL CORBETT: Because like Landauer gives you the meter report, but I don't know that the corrections ever show up on a meter report, to my knowledge.

MARK SEDDON: The meter report. No.

ADAM WEAVER: No. They just report the effective dose.

MARK SEDDON: Just the raw dose.

CHANTEL CORBETT: Right. So I don't know that there's a way unless you're the RSO for all those facilities, like to know whether they're doing correction facilities or not in any of them. So the meter report would be the only way to --

ADAM WEAVER: That's why you've got to keep track of them as well as you can.

MARK SEDDON: So maybe it's --

CHANTEL CORBETT: That's the rule is that no matter what license you're on --

ADAM WEAVER: You're going to have to live with it until --

CHANTEL CORBETT: Everywhere they're badged, they should be combined.

ADAM WEAVER: I mean, you must have a -- require them to notify you that they work -- they're working for you and then they work for --

MARK SEDDON: Right.

ADAM WEAVER: -- XYZ down the road or something.

MARK SEDDON: Or you review the meter report

and they're showing up somewhere else.

ADAM WEAVER: Only if they're using Landauer.

MARK SEDDON: Only if they're using Landauer.

CHANTEL CORBETT: Right.

ADAM WEAVER: A lot of places are trying to switch because Landauer is pricey.

CHANTEL CORBETT: Yeah. It's complicated.

MARK SEDDON: Okay. Well, I think -- since this is just for a registrant to follow, then I guess you don't have to worry about it since it's for individuals.

CLARK ELDREDGE: Any concern for moving forward once I do the updates?

JAMES FUTCH: I think you have the gavel. You're the vice-chair.

MARK SEDDON: Oh, yes. I'm sorry. Any further discussion on this?

(Laughter)

MARK SEDDON: We have a motion to approve -- move forward with the edits suggested by Clark.

JOSEPH DANEK: I go forward with the motion to approve.

MARK SEDDON: Second?

ADAM WEAVER: Second.

DR. RANDY SCHENKMAN: All in favor?

ALL: Aye.

MARK SEDDON: Any nays?

(No response)

MARK SEDDON: All right. Move forward.

CLARK ELDREDGE: Next.

ADAM WEAVER: Thank you, Clark.

JAMES FUTCH: Open another one of these?

CLARK ELDREDGE: Yeah.

JAMES FUTCH: Okay. Which one?

CLARK ELDREDGE: Either one.

ADAM WEAVER: The gonadal shield is pretty straightforward. Sign in.

JAMES FUTCH: This is what happens when you forget to activate your license before you leave town.

ADAM WEAVER: At least we got 64.

JOSEPH DANEK: Okay. Comments. That's the same -- no, actually, you got a --

ADAM WEAVER: Isn't it supposed to be dash five?

JOSEPH DANEK: Yeah. 64E 5 is wrong. It's just an editorial comment there. Correct that first sentence.

JAMES FUTCH: Let's let the lawyers do it.

JOSEPH DANEK: Yeah, they probably changed it.

JAMES FUTCH: They love that stuff.

JOSEPH DANEK: 5-502. Easy correction.

ADAM WEAVER: This is back from 2019?

CHANTEL CORBETT: You're very efficient.

JOSEPH DANEK: Are you correcting them right there in front of us?

CLARK ELDREDGE: He's correcting there; I'm correcting here. So we'll make plenty of mistakes when we try to combine them.

JAMES FUTCH: I'm not able to correct them.

CLARK ELDREDGE: I'm trying to -- I must have done a bulk replace. Why did it repeat so many times?

MARK SEDDON: So are there any questions or comments?

JOSEPH DANEK: I do, actually, because 502 ends after diagnostic procedure. Then the sentence that begins, this is only, this is the only instance, that's not a part of 502. That should be a separate paragraph. Do see where that is?

CHANTEL CORBETT: Yeah.

JOSEPH DANEK: It almost looks like that's --

CHANTEL CORBETT: Halfway through the paragraph.

JOSEPH DANEK: Yeah, halfway through the

paragraph. The way you read it, that's still part of 502 and it's not. It just becomes a separate paragraph.

JAMES FUTCH: It should be part of this?

JOSEPH DANEK: Yeah. Right there where it says -- right there. That's a separate paragraph.

REBECCA McFADDEN: New paragraph.

JOSEPH DANEK: And then in the following paragraph, it talks about the, it should be Australian College of Physical Scientists. Yeah, next to the last line.

ADAM WEAVER: Oh, yeah, what did they get there?

REBECCA McFADDEN: Yeah. Australiation.

CHANTEL CORBETT: You never know. It could be a thing. You never know.

REBECCA McFADDEN: Covering all bases.

JAMES FUTCH: Joining the continents together.

CHANTEL CORBETT: Asian, Australian.

CLARK ELDREDGE: It could be a pan.

JOSEPH DANEK: That's okay.

DR. NICHOLAS PLAXTON: The whole side of the hemisphere. North and south. A new name.

CHANTEL CORBETT: Eastern --

REBECCA McFADDEN: It probably is. It probably

auto corrected it.

ADAM WEAVER: Cindy, did you give them that name?

JOSEPH DANEK: Okay. A couple more. In the next to the last paragraph, last sentence. It's practitioner instead of prectitioners.

ADAM WEAVER: Licensed practitioner?

JOSEPH DANEK: Licensed practitioner.

ADAM WEAVER: Not quite.

JAMES FUTCH: There you go.

JOSEPH DANEK: One more. One more in the last sentence. It's Bureau of Radiation Control rather than --

JAMES FUTCH: Obviously, spellcheck is important.

JOSEPH DANEK: -- Radiaton (ph).

ADAM WEAVER: You can't spellcheck these documents.

MARK SEDDON: Are there any conceptual comments or discussions?

JOSEPH DANEK: Purely editorial. That's all I'm picking up. Actually, everything is editorial. That's it. That's all I have.

MARK SEDDON: I know we discussed this at previous meetings. I don't think there's any --

ADAM WEAVER: I think we voted on it before, too, didn't we?

MARK SEDDON: No, we never voted on it.

REBECCA McFADDEN: We created it.

MARK SEDDON: Well, we had a discussion and we clarified this saying that we as a group, decided that this was true. And then now Clark is, because of the constant calls and comments probably creating this to formalize what we had said and what the Department agrees.

ADAM WEAVER: And what the national --

MARK SEDDON: Matches all the national organizations.

CHANTEL CORBETT: Right.

ADAM WEAVER: Yeah. Okay.

REBECCA McFADDEN: And now we're grammatically --

CHANTEL CORBETT: Correct.

REBECCA McFADDEN: -- correct.

MARK SEDDON: Other than the editorial suggestions, are there any other comments? No? Do you have a motion?

CHANTEL CORBETT: Motion to accept.

MARK SEDDON: Accept? Second?

REBECCA McFADDEN: Second.

MARK SEDDON: All in favor?

ALL: Aye.

MARK SEDDON: Any nays?

(No response)

MARK SEDDON: No. All right. Very good. Next?

ADAM WEAVER: He's taking control. Good.

JAMES FUTCH: You get to see this one more time.

MARK SEDDON: This is the one Clark has presented to us a couple times. Was there any changes from last time?

CLARK ELDREDGE: Yes, there was. Let me try and get my copy. I can't read that that well. Okay. Here it is. Actually, there wasn't any significant change on this one.

MARK SEDDON: I didn't notice any.

CLARK ELDREDGE: No. Although on top of this one, I am -- there are recently two things that have come up, if I can remember both. The one is the fact that somebody received a dose outside of the therapy. They received a therapeutic dose when the therapy wasn't actually thought to be running.

JAMES FUTCH: Was this an engineering going on and someone was in the way and took the dose?

CLARK ELDREDGE: Yeah. It was an engineering problem. It was a hardware/software failure.

So as far as a rule proposed language and updating, expanding the definition of medical event to include those cases when a dose is provided to a patient completely unintended.

MARK SEDDON: But isn't there a separate regulation regarding that on exposure?

JAMES FUTCH: Unintended exposure?

MARK SEDDON: Yeah.

ADAM WEAVER: That would fall under unlicensed practice.

MARK SEDDON: Maybe I'm thinking somewhere else.

CLARK ELDREDGE: I mean, there are, but when a member of the public is exposed and things like that.

MARK SEDDON: Right.

CLARK ELDREDGE: There are other areas of exposure. It's not part of the medical event saying the medical facility, itself --

MARK SEDDON: Right. I gotcha.

CLARK ELDREDGE: -- needs to address the issue, analysis and all that.

ADAM WEAVER: Can you just go back up to the

top one.

JAMES FUTCH: Sure. Right here?

ADAM WEAVER: Yeah, number two. Wrong individual or human research subject.

JAMES FUTCH: It was the right individual but --

MARK SEDDON: That's the existing regulation.

CLARK ELDREDGE: Yeah, that's existing.

MARK SEDDON: In quotes.

ADAM WEAVER: I'm just wondering why do you call it research subject?

CHANTEL CORBETT: Because they're being researched.

ADAM WEAVER: I mean, we don't do any research.

CLARK ELDREDGE: You know, you'll have to ask whoever wrote that however long ago.

CHANTEL CORBETT: Prior to approval?

ADAM WEAVER: That means you have to get the IRB involved.

CHANTEL CORBETT: Well, that's what I'm saying. There's lot of those studies being done, though.

CLARK ELDREDGE: Yeah. I mean, this may go back to cancer research treatment.

ADAM WEAVER: Well, external beams --

MARK SEDDON: I think this is almost word for

word from the NRC, isn't it? Not NRC. CRCPD.

CLARK ELDREDGE: Yeah. I mean, you can certainly see that, when somebody was testing out IMRT or one of those new methodologies, that would've been -- technically, it hadn't been approved yet, so it would've been a research subject getting cancer treatment with a new modality.

CHANTEL CORBETT: Right.

GEORGE GILBRIDE: Well, wouldn't that work with, like, also, like, human research? That's also still experimental?

JAMES FUTCH: Human research subjects are not individuals.

MARK SEDDON: It's experimental, but it was, yeah.

GEORGE GILBRIDE: All right.

DR. NICHOLAS PLAXTON: The word subject you mean?

ADAM WEAVER: Huh? That's why I'm wondering why do you need the -- if you're the wrong individual, why do you need or human subject? Or human research subject?

JAMES FUTCH: The only thing I can think of is somebody objected.

GEORGE GILBRIDE: Okay.

DR. NICHOLAS PLAXTON: It does seem redundant.

CLARK ELDREDGE: That's why the human research subject language.

ADAM WEAVER: It just seems very redundant. Why --

DR. NICHOLAS PLAXTON: Individuals would be inclusive of human beings.

CHANTEL CORBETT: Right. That includes those other humans, right.

JAMES FUTCH: Maybe some lawyers got involved decades ago and said no, it doesn't.

DR. NICHOLAS PLAXTON: Probably.

CHANTEL CORBETT: Yeah. Same reason CT is not in the regs.

ADAM WEAVER: I mean, an individual would cover research or medically necessary.

DR. NICHOLAS PLAXTON: Yeah, all the above. In theory.

CLARK ELDREDGE: Well, we can change any natural person, you know.

CHANTEL CORBETT: Natural.

GEORGE GILBRIDE: Unnatural person.

JAMES FUTCH: Seriously, Clark, is individual defined in the regs? To only mean patients?

CLARK ELDREDGE: Excuse me? James, I couldn't

hear you.

JAMES FUTCH: Is individual defined narrowly in the regulations some place?

CLARK ELDREDGE: Not that I'm aware of.

MARK SEDDON: Any other comments on this particular one? I know we've talked about it before. Other than, I know you said you might be making another tweak to it.

CLARK ELDREDGE: Well, actually, I mean, it's a code standard that I need to -- it can't be in here because it's not code yet.

MARK SEDDON: Gotcha. Very good. So do we want to make a motion to move this to --

(Adam Weaver Leaves the Meeting)

JAMES FUTCH: You just lost your quorum. He walked out the door.

MARK SEDDON: Yeah, that's right.

DR. NICHOLAS PLAXTON: We were that close.

MARK SEDDON: No more bathroom breaks.

CHANTEL CORBETT: Well, we'll table that until he gets back.

MARK SEDDON: Yeah. Once he gets back -- as we close the meeting, we'll approve. But pending a return.

CHANTEL CORBETT: Pending Adam's approval.

REBECCA McFADDEN: We'll just yell at him over the stall.

(Laughter)

REBECCA McFADDEN: Are you in or are you out?

GEORGE GILBRIDE: Okay. You go ahead.

MARK SEDDON: All right. Do we want to move on to --

REBECCA McFADDEN: We need a yay or a nay. Now he's knocking on the bathroom door. Our quorum out there.

GEORGE GILBRIDE: Occupied.

JAMES FUTCH: Okay. Do you want me to do mine or try to start it anyway?

JOSEPH DANEK: Sounds good.

JAMES FUTCH: Okay. So I wanted to first tell you at the last meeting, we discussed some continuing education regulation changes to 64E-3.009. I'm not going to go back over all of that, but those are now in process. And hopefully, in another six months, they'll actually become part of the regulations.

These are the ones to change some of the activities to meet the national standards. Does anybody want to go over that again? No? Okay. Good.

And then in terms of reports for us in our section, we're currently in the time of year where we're doing, renewals have gone out for continuing education courses and providers. We have, I think, somewhere in the neighborhood of 650 providers and 4 to 5,000 courses, depending upon the time of year that you take the number.

The courses that we're working on will all expire at the end of January. So these are all the courses that are -- that we issued three years ago.

In terms of seeing -- sticking with the subject of CE, year to date, we've audited 40 CE courses and 13 providers. This is not something new, but the tracking of it. And the numbers is new because of the -- trying to comply with the national standards for proceeding.

CHANTEL CORBETT: Question on auditing.

JAMES FUTCH: Sure.

CHANTEL CORBETT: So when auditors come to audit a course, is it appropriate for them to get CEUs for those talks --

JAMES FUTCH: Are you saying this has happened?

CHANTEL CORBETT: -- as individuals? Just a question.

DR. NICHOLAS PLAXTON: That's a no.

JAMES FUTCH: Not typically.

CHANTEL CORBETT: Okay. That's kind of where my mind went to, but okay. Thanks.

JAMES FUTCH: Let me know -- if you know something that's going on, let me know.

CHANTEL CORBETT: Okay.

JAMES FUTCH: Dropping back into some of the weekly stuff. We have, typically, new courses being approved all the time. It varies from week to week and year to year. Currently, for the past couple weeks, it's about 40 new courses per week and that may be roughly tied to people realizing, oh, look. These courses need to be renewed. What about these other courses? Those aren't approved. Let's submit them and get them approved.

Any questions on the CE aspect, continue education aspects of it?

(Adam Weaver Reenters the Meeting)

JAMES FUTCH: Enforcement. It's always fun to talk about enforcement. Currently, we have 57 complete -- currently, we have 57 cases open against the radiologic technology profession, and those involve about the same number of rad techs. We also, because of being the Bureau of Radiation Control and the kinds of things that the inspectors

find or that the Department in MqA come and ask us about, we have also opened cases against other practitioners. Occasionally medical physicists, occasionally physicians, and we don't keep track of the numbers of those.

We're supposed to have a meeting to -- we do probable cause meetings probably every two months, and I think the next one is a couple weeks from today. And apparently, there's a couple medical physicists on the agenda for that one.

And I think that's almost it. Putting my IT hat on for a second, we're in the middle of trying to convert some of our older systems to more modern technologies that will allow for greater functionality and features. And that is probably year-long-type endeavor.

So that's it. Any questions?

CHANTEL CORBETT: It may be slightly off but connected. So I know that, you know, obviously, the more and more you go toward electronic capability and submitting things and whatever --

JAMES FUTCH: Go to the library. They always have access to web research.

CHANTEL CORBETT: No, no, no.

JAMES FUTCH: Oh, I thought this was somebody

that says, what if you don't have a computer?

CHANTEL CORBETT: No. I'm not in that field.

JAMES FUTCH: Where are you living?

CHANTEL CORBETT: The question is, are you also looking to be able to accept DocuSign signatures on submissions for applications?

ADAM WEAVER: License amendments?

CHANTEL CORBETT: Yeah, exactly. Because we have a lot of remote physicians and things like that these days.

ADAM WEAVER: Yep.

CHANTEL CORBETT: And not being able to send in a DocuSign as a signature is becoming more and more of an issue. So if that isn't part of the request going forward, I would appreciate it.

JAMES FUTCH: I do not believe it was, but I'm writing it down.

CHANTEL CORBETT: Add it.

ADAM WEAVER: It should be considered. I second that.

JOSEPH DANEK: Talk about seconding things, Clark, when you get back to this --

DR. NICHOLAS PLAXTON: Do we have a quorum?

CHANTEL CORBETT: Oh, yeah, wait. We have a quorum back. Adam is back.

MARK SEDDON: Adam is back, so we need to have a vote. We already have a second. We need a vote to approve the medical event draft notice that Clark has submitted. All in favor?

ALL: Aye.

MARK SEDDON: Any nays?

(No Response)

MARK SEDDON: No nays. All right. There you go.

Anything else, Clark?

CLARK ELDREDGE: I think we're good. I can probably come up with more, but let's call it now.

MARK SEDDON: James?

JAMES FUTCH: Nothing. I'm done.

MARK SEDDON: Anyone else?

ADAM WEAVER: We can be here longer.

MARK SEDDON: All right. We're all good. Meeting is adjourned.

CHANTEL CORBETT: Woo hoo.

JAMES FUTCH: And you will see some e-mails from Brenda about the next meeting dates and things like that.

ADAM WEAVER: April 19th.

CHANTEL CORBETT: Thank you everybody.

(Proceedings concluded at 2:41 p.m.)

CERTIFICATE OF REPORTER

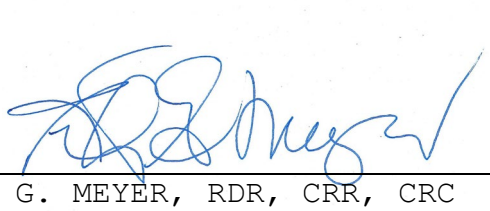
STATE OF FLORIDA:

COUNTY OF ORANGE:

I, RITA G. MEYER, RDR, CRR, CRC, do hereby certify that I was authorized to and did stenographically report the foregoing proceedings and that the foregoing transcript is a true and correct record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties, attorneys or counsel connected with the action, nor am I financially interested in the outcome of the action.

DATED this 27th day of December, 2021.



RITA G. MEYER, RDR, CRR, CRC