

ADVISORY COUNCIL ON RADIATION PROTECTION

Bureau of Radiation Control

Hilton Garden Inn Tampa Airport Westshore

Tampa, Florida

09/26/2017



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RADIATION
PROTECTION

**CERTIFIED
TRANSCRIPT**

Bureau of Radiation Control
Hilton Garden Inn
Tampa Airport Westshore
Tampa, Florida

Tuesday, September 26, 2017
10 a.m. - 2:19 p.m

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

1 ADVISORY COUNCIL MEMBERS PRESENT:

2 Randy Schenkman, M.D., Retired (Chairman)

3 Mark S. Seddon, M.P., DABR, DABMP (Vice-Chairman)

4 Alberto Tineo, CNMT

5 Adam Weaver

6 Chantel Corbett, AS, CNMT, RT(N), RSO

7 Kathleen Drotar, Ph.D., M.Ed., R.T. (R)(N)(T)

8 Christine Crane-Amores, RRA, RTCR

9 Brian Kent Birky, Ph.D.

10 william (Bill) W. Atherton, DC, DACBR, CCSP

11 Mark Wroblewski

12 Matthew Walser, PA-C, ATC

13 Efstratios D. Lagoutaris, DPM

14 DEPARTMENT OF HEALTH STAFF

15 Cynthia L. Becker, Bureau of Radiation Control

16 James Futch, Bureau of Radiation Control

17 Brenda Andrews, Bureau of Radiation Control

18 Douglass Cooke, Bureau of Radiation Control

19 Lynne Andresen, Bureau of Radiation Control

20 Lisa Gavathas, Bureau of Radiation Control

21 Sophie Aromoso, Bureau of Radiation Control

22 Also Present: Keith Nadaskay (Mayor of Wachula)

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1 RANDY SCHENKMAN, CHAIRPERSON: Good morning,
2 everybody. I hope everybody -- everyone and their
3 families did well during this last storm.

4 It's a little after ten. I was going to see if
5 we should wait for Kathy, but we decided we're going
6 to get started.

7 So as we usually do, we always introduce
8 ourselves. I'll start by introducing myself.

9 My name is Dr. Randy Schenkman. I am a
10 retired radiologist. And the hospital I worked at,
11 I started the women's imaging and breast imaging.
12 And even though I'm retired, I still try to stay up
13 with most things.

14 And now I'm going to turn it over to Brenda.

15 BRENDA ANDREWS: Good morning, everybody. Thank
16 you for getting here on time and safely.

17 And the first person I'm going to introduce is
18 one of our new members of the Bureau, and it is
19 Douglass Cooke. Some of you met him last night.
20 Douglass was hired with the Bureau as the business
21 consultant, which is the position that I was in
22 before. He has over seven years of experience
23 utilizing accounting, analytical problem solving
24 techniques, systems development and data analysis
25 skills.

1 He also has a background in staff training,
2 developing operating policies and procedures and
3 quality customer service. And Douglass will also
4 serve as my back up for the council so you will get
5 to know him a whole lot better during our meetings
6 and in the planning process.

7 So that's Douglass. And then Cindy is also
8 going to introduce our other new members.

9 CYNTHIA BECKER: Lisa.

10 LISA GAVATHAS: Lisa Gavathas.

11 CYNTHIA BECKER: She has many, many years of
12 experience, but interestingly enough, I first met
13 her in the Mississippi Department of Radiation. So
14 she started there and she came with us and was
15 working in the Fort Lauderdale area. So those of
16 you from that area might remember her doing
17 inspections down there. And we're lucky enough a
18 few months ago she transferred up to Tallahassee and
19 is now in the mammography coordinator position.

20 So if you remember Dan Okey who was in there
21 for years and years. Lynn was in there for a time
22 until she transferred. And now we have Lisa
23 Gavathas in there and so she brings many years of
24 experience in inspection and also licensing from old
25 days in Mississippi.

1 LISA GAVATHAS: I'm doing shielding as well.

2 CYNTHIA BECKER: Oh, shielding as well.

3 JAMES FUTCH: You left something out.

4 CYNTHIA BECKER: I did.

5 JAMES FUTCH: we'll fix that. would you like
6 more? We can give you more. There's no more money.

7 LISA GAVATHAS: Interim medical advance as
8 well, but we're hoping to pass that one.

9 CYNTHIA BECKER: Yes.

10 LYNN ANDRESEN: Oh, Lynn Andresen. I work for
11 James Futch in the radiologic technology program. I
12 specifically deal with enforcement issues of
13 technologists.

14 BRIAN BIRKY: I'm Brian Birky. I'm Executive
15 Director for the Florida Industrial Phosphate
16 Research Institute. And we are an institute within
17 Florida Polytechnic University, Florida's newest
18 public university. Twelfth university. And been
19 there since 2000 and executive director the last six
20 years.

21 CHANTEL CORBETT: Chantel Corbett. Nuclear
22 medicine technologist, Fusion Physics, a medical
23 physic consulting company. I'm also the TAG
24 representative for the Society of Nuclear Medicine
25 for the state of Florida and part of the FMT Council

1 for the state of Florida.

2 MATTHEW WALSER: Matt Walser, Gainesville,
3 Florida. UF Health PA in orthopedics. I am
4 currently on this board as a person that doesn't
5 know anything about anything. Radiology. But I
6 teach radiology for PT school up at UF and have been
7 up there for about 11 years.

8 STRATIS LAGOUTARIS: Stratis Lagoutaris from
9 Jacksonville, Florida. I'm a private practice
10 podiatrist.

11 ALBERT TINEO: Albert Tineo, Halifax Health,
12 Daytona Beach. I'm one of the administrators at
13 Halifax.

14 KEITH NADASKAY: I'm Keith Nadaskay. I work
15 for Mosaic. I, too, don't know anything. I just
16 came to kind of listen and you guys probably already
17 know this, but Brenda has a fantastic memory.

18 BRENDA ANDREWS: I'm so glad you said that
19 today.

20 BILL ATHERTON: Bill Atherton. I'm a
21 chiropractic radiologist in private practice in
22 Miami, Florida.

23 CHRISTINE CRANE-AMORES: My name is Christine
24 Crane-Amores. I'm a radiologist assistant up in
25 Tallahassee. I work for Radiology Associates of

1 Tallahassee and I've been in that position for the
2 last four years.

3 MARK WROBLEWSKI: Mark wroblewski. I'm an
4 basic machine operator and also office manager of a
5 couple offices Tampa, Florida.

6 KATHY DROTAR: Hi, I'm Kathy Drotar. I'm the
7 radiologist technologist therapy member and I am a
8 university department chair for radiologic
9 technology at Keiser University.

10 ADAM WEAVER: Adam Weaver, I'm the radiation
11 safety laser safety officer University of South
12 Florida. Primarily in Tampa.

13 SOPHIE AROMOSO: I'm Sophie Aromoso. I'm the
14 regulatory supervisor for this profession as well as
15 EMTs and paramedics. I've been with the department
16 about three years. I've worked with massage therapy
17 in investigations and consumer services and
18 acupuncture council, so I've been around for a
19 while. I'm excited to join you guys and be here
20 today. I didn't get to come last time.

21 MARK SEDDON: Mark Seddon. I'm the chief
22 physicist and emergency safety officer for Florida
23 Hospital System, which is pretty big. I've been
24 there about twenty years. I represent the medical
25 physicists on this council.

1 RANDY SCHENKMAN, CHAIRPERSON: I've introduced
2 myself. It's up to you.

3 JAMES FUTCH: I wasn't ready. It was the person
4 in front of me.

5 James Futch, health physicist for the Florida
6 of Bureau of Radiation Control responsible for RAD
7 tech certification. Sophie, preventive
8 radiological, nuclear power, all sorts of stuff.
9 But that's me, so --

10 CYNTHIA BECKER: Truly is everything.

11 JAMES FUTCH: Yeah.

12 CYNTHIA BECKER: I'm Cynthia Becker, Bureau
13 Chief, Bureau of Radiation Control. We kind of
14 skipped around. Been there for a number of years
15 working with James and with others. So welcome
16 everybody. All right.

17 RANDY SCHENKMAN, CHAIRPERSON: Brenda, you've
18 got to do it, too.

19 BRENDA ANDREWS: I am Brenda Andrews and I've
20 been with the Bureau since 2012. And I had the
21 fortunate opportunity to move up into the management
22 review specialist position. I report to Cindy and
23 I'm loving that. And so, I mainly do problematic
24 operations in overall kinds of things for the
25 Bureau. HR, budget, and those kinds of things.

1 RANDY SCHENKMAN, CHAIRPERSON: well, welcome
2 everybody. I guess the next thing in line is we
3 need to approve the minutes from the last meeting.
4 Is there a motion to approve?

5 KATHY DROTAR: I make a motion to approve the
6 minutes.

7 RANDY SCHENKMAN: Anybody second?

8 ALBERT TINEO: Second.

9 RANDY SCHENKMAN, CHAIRPERSON: Everybody in
10 favor say aye.

11 ALL MEMBERS: Aye.

12 RANDY SCHENKMAN, CHAIRPERSON: Anybody opposed?

13 (No Response)

14 RANDY SCHENKMAN, CHAIRPERSON: Okay. So we have
15 done that.

16 And now Sophie, your turn.

17 SOPHIE AMOROSO: I know Bianca had previously
18 and given an update on the amount of active licenses
19 we had, our processing timelines and we had some
20 issues we were working on with IT. So we have some
21 things that have been completed for IT. We have
22 some outstanding items, though, but I have an update
23 from them that we received this morning on the
24 outstanding items.

25 So our open applications. The previous number

1 Bianca had given the past presentation was 809. We
2 currently only have 592 open applications.

3 The previous number for the assistants was
4 seven. We currently have three.

5 Now these, I only did the data from the past
6 meeting where she stopped collecting data to
7 September 1st.

8 The number of clear and active licenses,
9 previously we had 27,191. We have increased that.

10 Our radiologic assistants actually stayed the
11 same since last May.

12 Average processing times 1.49, radiologic
13 technology. So this is the number of business days
14 it took to issue a license and that's after we deem
15 them qualified. So once they send in all their
16 documents, once their application is complete, they
17 may not have tested yet, but their application is
18 complete. That's when they're deemed qualified to
19 take their exam.

20 If they've already taken their exam, then it
21 gets done a lot more -- a lot quicker, but at this
22 time, it's from -- that time frame is just when we
23 approve them to take their test. It's not from the
24 time frame where they've taken it and they're
25 waiting to be licensed from that.

1 Okay. So these are the issues that we have
2 experienced. All the licenses that have expiration
3 dates over 24 months, those have all been
4 corrected. The temporary licenses for nuclear med
5 tech applicants, those have been corrected as well.
6 So the transaction on the online system wasn't
7 allowing them to go through. It's now corrected.

8 The expiration dates, where they had all been
9 given the August 2016 date, when they were given the
10 incorrect date to begin with, those have all been
11 corrected as well.

12 The initial licensure date of 1801, so we have
13 quite a few that show up that way. And I have an
14 e-mail from IT that we've got an update from that
15 this morning, so they have approved the change that
16 we requested to change all these license statuses
17 back, but they would also like to look through all
18 of our data to make sure we don't have any false
19 data.

20 So he says that the next, the realistic date
21 this would be completed is October 5th. And I'm
22 sure James and I will check back with them
23 consistently to see if that's been done or not.

24 JAMES FUTCH: Kathy just doesn't want anybody to
25 think she got her license in 1801.

1 KATHY DROTAR: No, I don't.

2 RANDY SCHENKMAN, CHAIRPERSON: Come on.

3 KATHY DROTAR: I've been around for a long time,
4 but that's a little further than, little further
5 back.

6 JAMES FUTCH: Steven's e-mail said there were a
7 number of other false dates that were showing up in
8 various peoples' data that was online. So 1801,
9 1901.

10 CHANTEL CORBETT: Mine's been 1901 since I
11 started. I'm right there with you.

12 JAMES FUTCH: Just in case anybody worries about
13 it, we have this online display that says, we're
14 primary source verified, so you can really trust
15 that anything you see online really is true. So
16 they hopped right on fixing this one.

17 So any time any of the computer databases that
18 we use has a null date or no date at all, between
19 the in-house system and the system that displays on
20 the website, when it saw the empty field, it just
21 made up what a computer thinks of is like the oldest
22 possible date for that system. So it will go to
23 1-1-1801, 1-1-1901. Probably even go to 1-1-2001 at
24 some point. Everybody realizes that's only 16
25 years ago.

1 KATHY DROTAR: That only showed up when you
2 went online to look for the licenses. It wasn't on
3 the one that was, that everybody hangs on the wall.

4 JAMES FUTCH: That's good.

5 KATHY DROTAR: That's a good thing.

6 SOPHIE AROMOSO: These are things we're just
7 working on right now. I have submitted a ticket,
8 because our ticketing system, that's how IT works
9 with us and fixes our issues. There was a lot of
10 not getting responses from us for applicants for a
11 lot of people. We currently have three RS1s who are
12 processors. So we have one RS2, she works with all
13 our exam modules and does all of our criminal
14 history; all the reviews with James. So I've spoken
15 with them about making sure they send out a
16 notification. No matter what, you get a document,
17 you say thank you, I've received this document, and
18 they send out the e-mail.

19 Now, for a licensure letter, they had no way of
20 knowing until the next day or unless we called them
21 because there's no letter that generated. A few
22 years ago, there used to be. So I put in this
23 ticket to create a global licensure letter. It's
24 actually going to be used for all professions. It's
25 going to have the profession name, the date you were

1 issued, your license type, all that information and
2 they're going to see if they can make it
3 automatically run so we don't have to go through the
4 steps. That's quite a few steps in an application
5 to go through all these things just to print a
6 letter to approve you. It's going to automatically
7 do that.

8 So we're currently working on those and
9 everybody has been getting licensure letters since
10 May. They should be getting an e-mail. If an
11 e-mail is on file, they get an e-mail sent to them
12 saying, congratulations, this is your license
13 number, and they can use that to verify with
14 whomever they need to.

15 And I also very well need to send an e-mail
16 from myself if you have any students or anybody
17 that's having issues with that.

18 VO uploads that is on --

19 JAMES FUTCH: What's VO?

20 SOPHIE AROMOSO: The online system.

21 JAMES FUTCH: Okay.

22 SOPHIE AROMOSO: So that is our online system
23 where you apply online. After you apply, you can
24 also upload your documents. And I talked with IT
25 about this because they don't receive a notification

1 that anything has been uploaded. So after quite
2 some time with this, they're still working on it and
3 there are still some roadblocks. They're going to
4 enhance the system, the entire online portal so they
5 will get responses back from those. Unfortunately,
6 the only way they can know if we received it is if
7 they see it in an attachment on their profile or if
8 they call us to ask.

9 CHANTEL CORBETT: So on that, if somebody is
10 either applying for renewal or something and they're
11 uploading a document, do they, at this point, need
12 to call in?

13 SOPHIE AROMOSO: I wouldn't request them to call
14 in. We have a --

15 CHANTEL CORBETT: I know that's a lot to you
16 guys, too.

17 SOPHIE AROMOSO: We have a report that we run
18 that's a VO uploads report. We run that daily. We
19 can -- we see all the items that they've uploaded
20 and we --

21 CHANTEL CORBETT: Okay.

22 SOPHIE AROMOSO: -- we issue the deficiency
23 letter if they needed any other document. So
24 they're aware it has been uploaded. I think that
25 that has been in -- that was something that we

1 increased our time on. I'm going to be able to
2 check that every single person daily because right
3 now, I have one person checking all of those
4 documents.

5 Helpful tips. Make sure students provide
6 social security number in their applications. On
7 the online system, it does not require you. There's
8 a little star there, but it's not a requirement.
9 That's false. But when they apply and they don't
10 have their social, we can't approve them to take the
11 test because ARRT won't allow us. And also, I get a
12 lot of calls from people stating that they can't
13 schedule with ARRT and everything has actually been
14 completed on our side, but they just haven't paid
15 ARRT.

16 So there's a little bit of confusion. I plan
17 on updating our website just to make it a lot easier
18 for you to follow the steps.

19 KATHY DROTAR: I just have a question on that,
20 too, since we encountered that. Hi. If their
21 number is -- because our students don't take -- they
22 don't schedule their tests through ARRT -- or
23 through DOH. They already have done it through
24 ARRT. But that same, same social security number
25 block was there.

1 SOPHIE AROMOSO: We have to have it on their
2 application.

3 KATHY DROTAR: Otherwise, we need to send you
4 the copy of the card.

5 SOPHIE AROMOSO: Yes, ma'am. Also, the name
6 they provide on the application -- this is a big
7 deal that we've had. Someone will include a middle
8 name. They will include a married name. But it's
9 not the same as what's on their license. And then
10 when they go to test or to register, they won't
11 allow them to. So we have to make those necessary
12 changes. We have to get those documents showing why
13 your name is changed, all that information, before
14 we can send them back to ARRT. So that's a delay in
15 the exam process for them.

16 This is just the reminder of the renewal
17 functions. They have been sent down to licensure
18 services. And you saw this in the previous
19 PowerPoint that you saw. Any calls, they're sent
20 downstairs. If we have anything in our, our ZZ box,
21 that's our main box that all of these go to if you
22 go to the Rad Tech e-mail. All of those, if they're
23 referring to renewals, we just automatically send
24 them a response and send them down to licensure so
25 they're aware we do not handle this, but they are in

1 the correct place.

2 Also, continuing education for their renewal.
3 And there is the information where they can reach
4 licensure services at.

5 Now, we have a new program operations
6 administrator. Her name is Irene Lake. She's been
7 with the Department about fifteen years. She's
8 working in prosecution services. She is wonderful.

9 Erica White is our executive director, which is
10 our unit manager. She's wonderful as well.

11 And that is it. Can I answer any questions?

12 RANDY SCHENKMAN, CHAIRPERSON: Anybody have
13 questions?

14 KATHY DROTAR: I'm sorry. I just wanted to
15 thank Sophie for all the support and help she's
16 given to our various programs because she's helped
17 us iron out a lot of difficulties and helping our
18 graduates get their licenses, so thank you.

19 SOPHIE AROMOSO: Thank you.

20 JAMES FUTCH: I wanted to follow up on a couple
21 of things that Sophie had mentioned.

22 Sophie, by the way, is, for those who have been
23 on the council for a number of years, remember Gail
24 Curry? Sophie is in the job that Gail was, Gail was
25 in many years ago. Gail is working in a different

1 part of MqA and we talk frequently; compare notes.
2 Especially on common problems on some of the things
3 that happened to the different professions.

4 But I also wanted to thank Sophie very much for
5 kind of shepherding all this and bringing it to us
6 and giving us a nice update.

7 Miss Bianca, who was here last time, Irene Lake
8 that Sophie mentioned, is, is taking Bianca's
9 position. Bianca has left the Department. Happy
10 doing something else, I hear.

11 SOPHIE AROMOSO: Yes.

12 JAMES FUTCH: And I also wanted to continue
13 everybody to tell us when you see things that are
14 wrong, especially with the computer systems -- that
15 seems to be the nexus of a lot of potential good and
16 a lot of things that have need to be fixed over the
17 years.

18 The 1801, basically, was something that Kathy
19 had noticed. The VO upload and not receiving notice
20 afterward is something Alberto had brought up, I
21 think at the last meeting. So thank you very much
22 and continuing sending that, sending that in to us.

23 Along the lines of the problems we had talked
24 about last time that Sophie very nicely followed up
25 on, I think covered just about everything I could

1 think of. We're also working on a complete
2 examination of the Versa online system to make sure
3 it comports with what the paper application requires
4 and what the regulation requires. And that's taken
5 a lot longer, because there are lots of nooks and
6 crannies and all of those online applications where
7 if you had yes this time instead of no, you skip an
8 entire screen that you don't see. And then you have
9 to go try and find what would happen if you answered
10 it this way. Is it doing the right thing.

11 SOPHIE AROMOSO: There's one gentleman in charge
12 of doing every single profession. Every single one.

13 JAMES FUTCH: Yes, we need to clone him. But --
14 so the, so the things like the social security
15 number required, that was one of the things that
16 we've got in the mix to, to actually make it do what
17 this -- what the rule and the statute and everything
18 else says, which is, yes, require it on the online
19 and don't allow people to, to not put it in. And in
20 the circular feedback report, Sophie's folks have to
21 go back out and get it from them.

22 And also, the way the system orders the whole
23 file attachment and the conviction history documents
24 and the background history, excuse me, the
25 disciplinary history documents, we're trying to

1 reorder that and, and apply some language changes so
2 it flows better -- and a bunch of other stuff that I
3 won't bring up -- but all of that is in the works.
4 And hopefully by the next council meeting, it will
5 be implemented and online. We'll see.

6 RANDY SCHENKMAN, CHAIRPERSON: Well, it looks
7 like it's a dramatic change from the last meeting as
8 far as time it takes to process the applications and
9 everything else, so congratulations.

10 SOPHIE AROMOSO: Thank you.

11 MARK WROBLEWSKI: Quick question. We noticed
12 that a lot of these smaller schools, latest being
13 Ultimate Medical Academy, have dropped their BMO
14 programs. Is there a list of schools in the area
15 that still have a BMO program? We've done a lot
16 with them. That's why I --

17 JAMES FUTCH: We actually, for the BMOs, it's
18 different from all the other professions.

19 MARK WROBLEWSKI: Sure.

20 JAMES FUTCH: Because the way the BMO statute is
21 structured, it doesn't require someone to attend the
22 formal education program as we would think of it.

23 MARK WROBLEWSKI: I understand.

24 JAMES FUTCH: Over the years, since I've been
25 with the Department, this function of the Department

1 since '98, because -- this is my theory -- because
2 of that fact, the number of BMO programs has, has
3 been shrinking. There used to be a lot more of them
4 at, at, you know, places like community college;
5 things of that nature.

6 So what we do now for the, for the best list is
7 we go to the Department of Education and there are
8 still several, I don't know the exact number, but
9 it's, you know, probably less than ten, almost all
10 of which, if I recall, are private, private
11 entities.

12 And then there are a number of medical
13 assisting programs that include a pretty hefty BMO
14 component. Kathy may know more about some of those.
15 And that's what, that's what comprises the best list
16 that we know about, which is basically the
17 Department of Education asked for anybody in the, in
18 the basic category.

19 MARK WROBLEWSKI: Thank you.

20 JAMES FUTCH: Sure. That's by statute. That's
21 not our, you know, the Department implements what's
22 in the statute. It's not necessarily what we would,
23 you know --

24 MARK WROBLEWSKI: No, I understand. I thought
25 maybe we had -- if you guys had a list.

1 SOPHIE AROMOSO: I'm going to look them up right
2 now. If I can find a list, I'll send it to you.

3 MARK WROBLEWSKI: Sure. Thank you.

4 RANDY SCHENKMAN, CHAIRPERSON: Any other
5 questions? Adam?

6 ADAM WEAVER: Will this work for me, too?

7 JAMES FUTCH: Let me pull it up, Adam. Hold on.

8 ADAM WEAVER: Okay. I just was asked to give a
9 quick overview, what we do at University of South
10 Florida in regard to --

11 JAMES FUTCH: When Adam says he was asked, he
12 was very gracious in providing this talk this
13 morning. And thank you very much.

14 ADAM WEAVER: Sure. Well, we have radioactive
15 material, which I'll discuss; x-ray machines and we
16 have some lasers.

17 You know, we have a radiation safety program to
18 comply with the Florida Statute; administrative
19 codes. We basically have two main radioactive
20 material licenses, 806-1 is our broad scope academic
21 license. I don't actually know how many are within
22 the state, but Cindy may cover that later on how
23 many broad scope academic.

24 But basically, what that allows us to do, we
25 have a radiation safety committee that meets and

1 when someone wants to use radioactive material in
2 his or her research, non-human research, they have
3 an application they fill out, the committee reviews
4 it, either approve it or we go back. And if they
5 have questions for what radioactive material they
6 need to use for their research.

7 The committee is made up of other faculty
8 members that are experienced using radioactive
9 material in their research, so it's a peer review.
10 And we also have an administrative, typical on most
11 radiation safety committees.

12 we also have another license for gamma research
13 radiators, which are used for cell, mostly cell
14 studies. And we also -- I'm also associated, which
15 Chantel knows the Byrd, PET CT license, because they
16 do a lot of research there.

17 I didn't know it did the fading. Cool.

18 so basically, I already summarized that. So
19 whenever a new researcher comes to University of
20 South Florida, he or she may be coming from up north
21 or another university, so we run things a little bit
22 different. So we just go over -- the application's
23 only three pages long. We help them fill it out.
24 So we're very user friendly to try to, you know, if
25 they need to use it and it's an appropriate use,

1 then we work with them to get them to use the
2 radioactive material safely.

3 And I'm not going to read through all this, but
4 basically, the office is, myself, a health
5 physicist, and one radiation safety technician. We
6 have about 50 approved principal investigators.
7 Maybe half of them use it during the year. So some
8 of them get a permit because some of the grants that
9 they go after require them to have radioactive
10 material approvals to use it. They may never plan
11 to use it, but some grants, like NIH grants or
12 something like that, may require them to have the
13 capability of using radioactive material. So a lot
14 of people have it for those reasons. Not
15 necessarily they are planning to use it in their
16 research.

17 But we do all this -- the operations for the
18 researchers is centralized. We order the material.
19 We receive it; we bring it to them; set it up. We
20 give them all the materials to use it safely.

21 We do a lot of surveys. We have a couple --
22 quite a number of x-ray machines. That's why the
23 state likes to come to our x-ray inspections. I
24 think right now we have 25. All non-human use.
25 Most of them are analytical.

1 Does this have a little laser? I see it.

2 This is a typical analytical machine. The
3 actual beam size is, is like microns. But it's a
4 very intense beam. This, this is a typical one for
5 cell radiation. This one could be used for small
6 animals or for doing localized x-rays.

7 And this is actually a small, a small animal CT
8 that also has a PET component to it and a SPECT
9 component to it. So we can do the full set up for
10 doing imaging.

11 so we still have some fraction units, cavity
12 units; things like that.

13 If you have any questions or anything, feel
14 free to ask.

15 These are the common radioactive materials,
16 just based on their toxicity, of what we're using at
17 the university. We use, you know, the cesium is in
18 the gamma radiators. We don't use it as an unsealed
19 source. We use very small amounts of iodine.

20 When I first got to the university about 17
21 years ago, a lot of people were doing their
22 ionizations, which used maybe five to ten millicurie
23 amounts to get a product of maybe 200 to 300
24 microcuries out of it. But now all that's done by
25 the great -- the big manufacturers, the Perk and

1 Elmers, American Radio Chemical, big companies like
2 that. No one does ionizations anymore at university
3 level that I'm aware of.

4 We do a lot of the medium to low Phosphorus-32
5 is very common. Carbon-14. Chromium-51. Some of
6 the other ones, exotics, some people use them. We
7 have a lot of researchers using Tritium in the
8 biomedical research, various studies.

9 One of the new ones that we're using, I'll talk
10 more about later, is Actinium-225. And actually,
11 there's someone -- there's a component out of, I
12 think Sloan Kettering up in New York with a company
13 called Actinium Radio Pharmacy or Pharmaceuticals.
14 I don't know if you guys have got it, but there's a
15 phase three of a drug that's out there now being
16 used. It gives quite good results for a -- I think
17 theirs is for leukemia. We're looking at another
18 end of it. These are based -- the rankings are just
19 based on relative toxicity.

20 I'm not going to spend a lot of this, but if
21 you've ever worked with Carbon-14, you know it has a
22 very long half-life. It's going to be around for a
23 long time. We do use a lot of tritium because
24 that's very common and acts just like the regular
25 hydrogen, so you can use it in various things. Very

1 low energies.

2 S-35, it's kind of expensive to use, but some
3 people do use it.

4 Again, the P-32, these are the shorter
5 half-life materials. We're allowed to hold anything
6 per regulation for decay and storage of less than
7 120 days half-life.

8 Iodine-125, usually when people use that, they
9 use it in what's called RIA kits now. Very small
10 quantities, five to ten microcuries. Very, very
11 small amounts. Usually we don't need a lot of
12 shielding working with that material now.

13 Chromium, we have a couple researchers that use
14 this pretty regularly. It's used for a couple
15 different assays and it does require a little bit of
16 shielding. It does have primarily a gamma emitter,
17 but again, not, not high energy.

18 These are kind of the things that Moffitt, we
19 help out with Moffitt's non-human research and one
20 of their big groups is the sale imaging for small
21 animal imaging.

22 Positron, I'm sure most everybody knows what
23 that is. Here, we do a little SPECT isotope again.
24 We had that one machine that can do, usually, you
25 know, you run the CT on the, on the animal and then

1 you can do either do a SPECT imaging or PET imaging
2 depending on what isotope you're checking into.

3 This is a relatively new. We've been doing it
4 for about two years. Actinium-225. It's another
5 alpha emitter. We haven't started using it yet, but
6 it's used in some hospitals for pain management.
7 You've probably heard of that.

8 Radium-223. So that's pretty much established.
9 But we have a couple researchers looking at it from
10 another end, maybe for some other possible therapy.

11 But Actinium is used as a therapy, an alpha
12 emitter, therapy drug. It's very -- it works great.
13 I can't show any pictures, but we have -- we've
14 taken pictures where the animal has a tumor, and
15 after the treatment, the tumor is essentially gone.
16 So right now, they're working on a type of skin
17 cancer that's very -- that spreads very rapidly.

18 So we get the, we get the, actually the
19 material comes from Oakridge. It's from the -- it's
20 kind of a waste product of Uranium-233, which is
21 produced in the reactor in Pittsburgh a long time
22 ago, in some of the DOE reactors. It comes out as a
23 nitrate, but we, we work with another university who
24 converts it into a liquid. They basically add a
25 chelator to it and they add a peptide to it, various

1 peptides, to try to get the drug go where we want it
2 to go in the body or in the animal. So that's where
3 it's, it's made up in Oakridge.

4 This is how we get it as the Actinium drug and
5 you can see there's, there's, I believe, five alphas
6 for decay and they're very high energy, alphas.
7 After the ten days, it's very rapid. Very short
8 half lives. So if you get an alpha to the tumor, in
9 the area of the tumor, that's a lot of energy that
10 can potentially kill the tumor. And so far, we're
11 seeing it -- we're still, you know, there's still a
12 lot of work, very early work, but Actinium seems to
13 be -- and other universities are using it. And
14 again, I believe there's one, one or two drugs in
15 phase three trial.

16 MARK SEDDON: I got a proposal last week.

17 ADAM WEAVER: Yeah, they are trying to get into
18 Florida.

19 So we started using this again in an area that
20 we initially set up to do PET and SPECT imaging and
21 we didn't need all that shielding for Actinium.
22 There's not a lot of -- there's some gammas
23 associated with it, but they're very low yields and
24 no where near the PET isotope energies or the SPECT
25 with like Tech or Valium.

1 But the big concern when you're working with
2 Actinium is annual limit of intake. You don't want
3 to get it into your body. I've worked with alpha
4 emitters before, so we're very careful with it. We
5 use it in very small quantities. We usually get it
6 in maybe, maybe we get 500 microcuries from our
7 other university that we're working with.

8 As you can tell, it's much lower, much more
9 controlled, just comparing the annual limit of
10 intakes, for injection, oral inhalation, you can see
11 Actinium is a tiny amount to get into you, to get to
12 your annual limit of intake.

13 So it's just a common comparison. These are
14 what we typically work with, very high, you know,
15 very easy to work with, but we had to put a lot more
16 controls when we're working with Actinium. Because
17 we're -- we basically get it as a, in little tiny
18 vials, and we have to put it in syringes, so it's a
19 lot of work. You've got to be careful when you're
20 handling syringes with this material.

21 So some of the control measures that we put in
22 place. Specific training. We have a crew of maybe
23 five, six people that work with us. We do a lot,
24 helping out a lot of work. We do use L shields;
25 some engineering controls, not necessarily for

1 shielding purposes, but primarily to make sure if
2 there's everything -- but you're injecting it into
3 live animals. We can get a splash or mishap with a
4 syringe. So everyone's, you know, we go through the
5 training, we review the training every time we use
6 it. We do it about quarterly. That's typical what
7 we're working with.

8 We do a lot of bench coating. We cover the
9 whole area. It's kind of like the old, if you do
10 iodine therapy, you remember all the covering all
11 the surfaces in the bathrooms and whatnot. We do
12 the same thing when we're working with Actinium
13 because it, like most alpha emitters, it will travel
14 around. So you want to make sure it's on absorbent
15 material quickly and at the source when you're
16 working or near the source.

17 We always cover all our carts. And we dedicate
18 pipets, tweezers and syringes for this work. We
19 don't -- they're segregated. We hold them for decay
20 most of the time. We don't use them for other
21 projects.

22 We always wear double gloves. We find that a
23 very thick glove and then a thinner nitro gloves on
24 the outside. And we, and we replace those
25 frequently.

1 We can detect Actinium very easily with a
2 meter, level three or 14C with a pancake probe works
3 very well. We cover the probes with, usually a wax
4 material to keep -- prevent them from getting
5 contaminated.

6 We also have a pressurized ion chamber to
7 measure dose rates if we need to; things like that.
8 And we, we wear Tyvek rather than the regular lab
9 coats to prevent the -- because those are, you know,
10 resist the absorption of water; moisture.

11 One of the big concerns we have, we have dose
12 calibrators down in these areas. It's the same,
13 essentially the same one that you would have in a
14 nuclear medicine department. But we're using it
15 for, for research, so we had to figure out -- we
16 talked to the manufacturers about settings. We
17 talked to other users of Actinium, but they
18 actually -- no one was using a biodex. We basically
19 had to come up with our own.

20 We came up with one and so far, it seems to be
21 working pretty well. Again, we're comparing it to
22 where we're getting it from, our other university
23 that we work with on this project.

24 So it's all over the place. But we -- and
25 that's where we're doing more work on now is to get

1 more information on the detection on our -- on this
2 operation.

3 But the three main things as the health
4 physicist, radiation safety officer, I want to make
5 sure we can detect the contamination, and can we
6 detect -- do we know what it is from. If there's
7 any other contamination. So because we can always
8 do liquid scintillation counters. We have a liquid
9 scintillation counter that can give you a spectrum
10 on it. So that's what the Actinium-225 spectrum
11 looks like. That's primarily from the alpha, the
12 various alphas. Again, it's five alphas per decay
13 through the daughters.

14 This is a -- you're probably familiar with the
15 white counters most people have in their nuclear
16 medicine labs. It's the sodium iodine thallium well
17 counter. Typically, I think it's a half-inch well.
18 So that's the spectrum we get with Actinium. So we
19 use that also for information where we run it with a
20 dose calibrator.

21 And we also have access to a high purity
22 triammonium gamma system, which can definitely show
23 the peaks. This one is, I believe, 140, 140 or 230
24 and 440. Something like that.

25 so they're very distinct peaks, but you can

1 still see them with that. We can definitely tell
2 that it's Actinium because we've run other samples.
3 We've printed out other spectrums. So we can --
4 it's a way we can determine is our contamination
5 Actinium or something else.

6 So one of the lessons learned working with
7 Actinium, and you've probably read some stories
8 recently about it, probably acts very similar to the
9 Actinium -- no, excuse me, Americium-241 that's in
10 the news right now. It sticks to everything and it
11 will want to travel. It's basically because of the
12 recoil atom of the -- when it emits the alpha, the
13 atom has so much energy, it moves. But liquid
14 scintillation counting works very well. It's very
15 sensitive.

16 So that's our preferred method, but we don't
17 have liquid scintillation down in the scan room, so
18 we have to run the scans over to the med school,
19 which is only about a two-minute walk, so it's not a
20 big deal.

21 We found that alcohol works really well to
22 clean up for decontamination, especially if you get
23 to it early. So if we know we have a problem, we
24 clean it up fairly quickly.

25 That's also pointed out, we do have lasers at

1 the university as James is aware.

2 JAMES FUTCH: I like your warning.

3 ADAM WEAVER: Yeah. You know, we basically,
4 there's four major classes. Lasers are very cool,
5 very useful, but they can be very dangerous. And
6 this is -- when I first got to the university, this
7 is one of our most powerful lasers was an old CO2
8 TEA laser in the physics department. It was
9 actually made there. And they actually pumped the
10 gas into it. It leaked all the time CO2, but it
11 produced a pretty strong beam. But now you can get
12 a stronger laser down to this size (indicating).

13 JAMES FUTCH: Is that an actual cathode ray tube
14 on the device, bottom right corner over there on the
15 floor, a monitor? Computer monitor?

16 ADAM WEAVER: Yes, an old picture.

17 JAMES FUTCH: Is that a dot matrix printer on
18 top of it?

19 ADAM WEAVER: It is an old picture. But we --
20 our physics department was very proud of these
21 lasers and they worked when you get the seals all
22 right and -- but they took up pretty much a whole
23 lab. And now you can get the same energies, even a
24 better quality beam, which is what they are very
25 interested in, down in a size, probably even smaller

1 than this now.

2 And then they're even getting smaller. Lasers
3 are getting smaller.

4 JAMES FUTCH: Thanks to diodes.

5 ADAM WEAVER: These diodes can be very powerful
6 now. Depending on what filters they put into them
7 or don't put into them can present a hazard because,
8 you know, these diodes, they probably cost probably
9 fifty cents to make in a mass manufacturing plant.
10 And you put them together, they can produce a Class
11 3B or 4 laser, which can be pretty much, you could
12 easily fit this in your hand.

13 JAMES FUTCH: And the colors, too.

14 ADAM WEAVER: Yeah, and the various colors.
15 That's one of the big concerns. So I just threw
16 that in there, just to -- And then, of course, you
17 did have sound.

18 I worked at the Department of Energy a long
19 time ago. I always like these old signs, so. And
20 this is one of my favorites surveys. We're there to
21 help everybody do the research.

22 So thank you for your time. I hope I wasn't
23 too fast. If anyone has any questions or anything.

24 RANDY SCHENKMAN, CHAIRPERSON: When you use
25 this, the Actinium in --

1 ADAM WEAVER: Yes.

2 RANDY SCHENKMAN, CHAIRPERSON: -- animals.

3 ADAM WEAVER: Yes.

4 RANDY SCHENKMAN, CHAIRPERSON: If it's so
5 potent, what happens to the animals, themselves?

6 ADAM WEAVER: We use it in mice. Primarily
7 mice. The animals are sacrificed at the end and we
8 analyze their tissues and --

9 RANDY SCHENKMAN, CHAIRPERSON: You have to --
10 are you giving it systemically?

11 ADAM WEAVER: Do a tail vein injection. These
12 animals are stored in a controlled area, and we
13 have -- and there's various studies, because we
14 put -- we inject, like, different amounts in each,
15 in to various groups of animals.

16 RANDY SCHENKMAN, CHAIRPERSON: But what happens
17 to them before they're sacrificed? Does this kill
18 them or does this only go to the site because of
19 whatever --

20 ADAM WEAVER: It mostly goes to the site, but
21 some of it does go to the liver and the kidneys, you
22 know, because it is -- but we haven't seen any -- we
23 have a level right now that doesn't kill the
24 animals. So we keep it -- if we keep it below eight
25 microcuries per the animals, because the animals are

1 maybe, maybe 100 to 150 grams, they are very small
2 animals. So -- and it's a very small amount that we
3 inject that in volume wise and the flush afterwards
4 is very small. Because we're working with the vets,
5 you know. All this is approved by our IACUC
6 Committee, which the university has. And the vets
7 are always, you know, keeping on us to make sure
8 we're doing it right and we're very careful with the
9 injections.

10 But we have a space that's separate from the
11 rest of the animal population where we store these
12 animals. We change their beddings, what their
13 requirements are; things like that. And the bedding
14 unfortunately is, we hold it for decay, so our waste
15 site really gets smelly. But, you know, that's --
16 but it is -- that's a good question.

17 MARK SEDDON: Is there a reason why you guys are
18 working with Actinium versus Uranium for your PI?

19 ADAM WEAVER: This Actinium, it seems to be so
20 effective.

21 MARK SEDDON: More effective than Radium.

22 ADAM WEAVER: Radium has, I think, one or two
23 alphas with its decay. And I think the Actinium
24 right now, it can be manipulated easier.

25 MARK SEDDON: For binding.

1 ADAM WEAVER: It works well with a, you know,
2 typical chelating agent, like DOTA, something like
3 that. So chelators work really well with it and
4 they get into a peptide or protein, whatever they
5 are trying to work with, and it seems to go -- they
6 get enough to the tumor that it kills -- seems to
7 really work.

8 Again, it's very early phases. For us, what
9 the Sloan Kettering does is more of a whole body.

10 MARK SEDDON: With leukemia.

11 ADAM WEAVER: Yeah. They had a couple different
12 forms. Different chemical groups.

13 MARK SEDDON: Their binding is antibody. So
14 it's pretty effective.

15 ADAM WEAVER: Yeah.

16 MARK SEDDON: Okay.

17 CYNTHIA BECKER: Adam, it sounds like you share
18 with other universities your experiences. What,
19 what method do you, do you guys do that as --

20 ADAM WEAVER: I mean, you know, everybody wants
21 to publish papers.

22 CYNTHIA BECKER: Right.

23 ADAM WEAVER: There's a couple papers in the
24 works. And in Sloan, I mean, they -- because
25 there's is now in Phase 3, when they were doing the

1 initial research, they shared a little bit, but not,
2 you know, because everybody wants to have their
3 magic drugs. So usually these are tied to some kind
4 of drug manufacturer or potential patent.

5 So there is some sharing. But we do share the
6 experience and I don't know if you can put it up
7 there, but we've been working on a -- there's
8 another PDF, an Actinium -- in radiation safety, we
9 like to have, you know, it all in one page. So
10 we've been working on a radiation safety data sheet
11 that we're trying to get out there.

12 Brian probably knows, there's a lot of them out
13 there for it and I think some are in your -- I don't
14 think they're in your book, but some --

15 BRIAN BIRKY: Not specifically.

16 ADAM WEAVER: We couldn't find a lot of
17 information on Actinium, so we're trying to put one
18 together. I don't know if you could find it.

19 JAMES FUTCH: There it is.

20 ADAM WEAVER: We've been trying to put something
21 like this together so it's all in one place for
22 other researchers that are potentially going to be
23 using it, because I know there's an actual company
24 out there that's pushing the Phase 3 drug.

25 MARK SEDDON: Actinium Pharmaceuticals.

1 ADAM WEAVER: Yeah, that's right. And they are
2 working with it. I think the medical physicist
3 who's going to be calling potential hospitals in
4 Florida, getting it on this Phase 3 trial. So this
5 would be helpful, we think, to, you know -- it's a
6 very common format, so we're trying to put it
7 together. As soon as we get it further along, we'll
8 share it out.

9 CYNTHIA BECKER: Great.

10 JAMES FUTCH: So, Adam, when you're working
11 something like this, the eventual intended use is,
12 is people, hopefully.

13 ADAM WEAVER: Right.

14 JAMES FUTCH: So method of administration versus
15 extreme toxicity, how does that balance?

16 ADAM WEAVER: That's why there's more research
17 that needs to be done. I mean, because typically,
18 when you're doing alpha emitters, you know, most of
19 your imaging you're putting millicurie amounts in.
20 when you're doing alpha emitters, you're talking
21 microcurie amounts. Even with the Radium, I think
22 the dose is maybe 50 to 100 microcuries, but it's a,
23 it's a much smaller amount of radioactive material
24 because of the potential radio toxicity. Because
25 these are alpha emitters, that means they are higher

1 atomic numbers so they can be a problem with the
2 kidneys, problem with the liver. But if you get
3 that right balance, then it potentially, you know,
4 right now it's the bone, it's mostly for palliative
5 care, but it works really well, from what I
6 understand.

7 MARK SEDDON: Yeah. They're finding it to be
8 pretty effective. Most of the administrations are
9 palliative, so your patients aren't -- are less
10 fibrous.

11 CHANTEL CORBETT: what are your badge ratings
12 on the people? You said you had five users using
13 this.

14 ADAM WEAVER: Minimal. I don't think we had a
15 positive reading. We have finger rings, too, we're
16 working with.

17 CHANTEL CORBETT: I saw that.

18 ADAM WEAVER: Yeah. It's very low.

19 MARK SEDDON: Do they even measure?

20 ADAM WEAVER: I don't think we had a positive
21 measure. It's tough because at the same time, we do
22 a little F18 research and C11 research.

23 CHANTEL CORBETT: You've got enough of it.

24 ADAM WEAVER: Right. We actually have a -- we
25 do actually C11 research, too, which is a very short

1 half-life material. Still again, non-human
2 research. Very quick.

3 JAMES FUTCH: You mentioned papers in process
4 for publication. Which journals are you typically
5 seeing this kind of research?

6 ADAM WEAVER: What are the various cancer -- I
7 don't know. There's so many different cancer --

8 JAMES FUTCH: Mainstream. Specialized for --

9 ADAM WEAVER: Yeah. But I know a lot of people
10 are working on it and we have one, a couple guys
11 that are working just on the detection end of it to
12 try to, you know, because that's one of the
13 questions when you put it into a dose calibrator and
14 you have so many different alpha emitters, how do
15 you know the amount of Actinium versus the
16 daughters? And that's going to be hard to -- so
17 they're working on that now.

18 MARK SEDDON: You guys are doing imaging studies
19 with the --

20 ADAM WEAVER: Yes. We can image it.

21 MARK SEDDON: Okay.

22 ADAM WEAVER: The SPECT image on that equipment
23 that we have isn't the greatest so we've actually
24 been bringing them to nuclear medicine where we, you
25 know, package the animal up. It can actually be

1 seen there on a, on a good SPECT system. So that's
2 an interesting point that they're looking at, too.

3 Again, this is all early phase. We've been
4 working with it probably, I think about two years.
5 I think, I'm sure Sloan Kettering and those folks
6 have been working with it even longer because I
7 think that Actinium Pharmaceuticals was a spin off
8 of Sloan. But Oakridge has been producing or has
9 the capability of producing 150 millicuries a year.
10 So if we go exceed that amount, then they're going
11 to have to -- and some of the national labs are
12 looking at producing Actinium in maybe some
13 accelerators. There are ways to do it in some of
14 the higher energy accelerators.

15 CYNTHIA BECKER: So, Adam, this brings to mind,
16 as you know from being in our group before, at what
17 point can we introduce our inspections staff to
18 figure out what changes they would be encountering
19 when they inspect? And I don't know, you know, I
20 know it's the early phases, but you, you are working
21 with it now.

22 ADAM WEAVER: Right.

23 CYNTHIA BECKER: Just trying to figure out --

24 ADAM WEAVER: We've invited -- they can come
25 down and watch us.

1 CYNTHIA BECKER: Okay. That was going to be my
2 next question.

3 ADAM WEAVER: Any time.

4 JAMES FUTCH: She didn't want to really ask.

5 CYNTHIA BECKER: I was trying to beat around
6 that bush.

7 ADAM WEAVER: The only thing they may not want
8 you to do is take pictures because they don't like
9 pictures unless, or something -- but beyond that,
10 you guys don't take pictures during your inspections
11 most of the time anyway.

12 CYNTHIA BECKER: No, but we are trying to get
13 our technical staff together at some point, maybe
14 January, February, March time frame, probably in
15 Orlando area, but maybe that's something we can talk
16 about.

17 ADAM WEAVER: Sure.

18 CYNTHIA BECKER: Okay. Thank you.

19 ADAM WEAVER: All right. Well, thanks.

20 RANDY SCHENKMAN, CHAIRPERSON: Anybody have any
21 other questions? Comments? Okay. So now we're
22 going to move on to Lisa.

23 LISA GAVATHAS: Okay. As Cindy said, I just
24 moved to Tallahassee, I think in July, and started
25 with the program there. I was an inspector in the

1 field before that, so I'm learning.

2 Forewarning, when I was invited to come to, to
3 the advisory council meeting, I thought it was just
4 a free trip to come and see what was going on. And
5 last week, I learned I actually had to say
6 something. So I didn't have a lot of time to
7 prepare, but I'm going to basically give you a
8 rundown of the program.

9 As of right now, we have seven employees full
10 time. Six of those employees are in Tallahassee.
11 One is teleworking from the Jacksonville area,
12 Willie Burgess, and I think he's been -- he was as
13 of the last meeting, he was also teleworking then.

14 We do have one advertised position who will be
15 handling medical events and I will be really happy
16 when that person is hired. And they will also be
17 doing violation correction, so if anybody knows of
18 anyone who is interested in coming to work for the
19 state, we have that position. It's open right now.

20 I did add a hand out in our pamphlet here. It
21 kind of gives us a breakdown of how many facilities
22 based on what kind of facility we have. Right now,
23 we have over 19 -- around 19,000 active facilities
24 and that amounts to over 54,000 active tubes in the
25 state.

1 As you can see, if you look at the handout,
2 most of our facilities are dental. We have over
3 7800 dental facilities in the state, which amounts
4 to 32,000 of our tubes. A lot of inspections.

5 We -- the rest, we have hospitals, you can kind
6 of -- there's a legend on the second page that tells
7 you what kind of facility there is.

8 We're also currently in the renewal phase,
9 which is when we send out all of the renewal
10 notices. Those have not, as of yesterday, gone out.

11 Everything -- I note that during the last
12 council meeting, it was discussed about staggering
13 the renewal times, but that hasn't gone into effect.
14 We haven't come up with any plan to do that and I
15 don't know that there would be anything happening in
16 the near future with that.

17 So all of our registrations expire as of
18 October 28th. It's a really busy time for the x-ray
19 program, so as soon as these go out, we'll be -- I
20 think everybody will be working with renewals trying
21 to get those out.

22 The other thing we do is mammo, mammography,
23 which I was hired to be the coordinator for the
24 state, but I have not gone through all of my
25 training yet. So I'm working with someone who's

1 doing the interim, the interim coordinator, Nick
2 Patkashe1 (ph), who was excellent. But if you have
3 any questions, you can always call us.

4 As you know, the FDA regulates mammography. We
5 have a contract with the FDA. As of the last
6 council meeting, that had not been signed. However,
7 all the items have been worked out. Everything --
8 the mammos contract has been signed and went into
9 effect on September 1st and the inspectors are now
10 back out doing inspections.

11 The other, something else. Also, registered
12 vendors. I think it's a free service, if I'm not
13 mistaken, but anybody that comes in to the state to
14 work on x-ray machines to do any kind of service,
15 they have to be registered in the State of Florida.
16 And we handle those registrations as well.

17 The other big issue we have is medical events.
18 Any medical event that is reported to us has to be
19 investigated. And we have Lynn here that's going to
20 give us a run down on medical events that have
21 happened in the past and give us some -- and what
22 we're trying to do in trying to improve the program.

23 LYNN ANDRESEN: Okay. So we at the Bureau of
24 Radiation Control, we're in the process of creating
25 a more collaborative investigative team approach to

1 medical event investigations and report
2 preparations. So when a medical event occurs, we
3 typically receive a call from a medical physicist at
4 the facility. And that call goes to the radiation
5 machine program section, where Lisa is the interim
6 coordinator for that position. And she will
7 schedule or that person will schedule an
8 investigative site visit at the facility. We try to
9 do that within a two-week time frame.

10 And then an investigative team, a
11 representative of the x-ray program, right now Lisa,
12 myself for technology, and a representative from the
13 inspections program will go out and will conduct a
14 site visit and will gather information. It's a
15 fact-finding mission. We'll conduct interviews of
16 the therapists or the technologists, medical
17 physicists, whoever was involved with the event.
18 We'll take that information back; compile a report;
19 submit the report to the program administrators and
20 the Bureau chief for their approval. And at that
21 time, it will be determined whether a facility
22 violation has occurred. If a fine will be imposed,
23 we'll notify the facility of that determination and
24 let them know about an appeal process if that's
25 warranted.

1 Also, with technology, we will determine if a
2 technology violation has occurred. And if so, then
3 we will file a complaint with MqA for action.

4 So, also, I want to share that all the BRC
5 investigative team members have been through
6 advanced investigative training with MqA. That's
7 the division of Medical Quality Assurance. They
8 have a huge investigative section in that division.
9 And we've learned a lot as far as interviewing,
10 evidence collection, report writing -- can you add
11 anything else that -- very informative. About a
12 two-week training period. A basic course and an
13 advanced course. And we appreciate them allowing us
14 to participate with that process.

15 I also wanted to just share a couple of
16 examples of medical events that have been
17 investigated by the Bureau. One was a patient who
18 received treatment to the wrong site. Second round
19 of treatment was given to the first treatment site
20 incorrectly. Six treatments were delivered before
21 the error was discovered. So that was one example.

22 Another example, patient who received more than
23 thirty percent of the weekly prescribed dose.
24 Patient was prescribed qd or once daily treatment,
25 but was treated bid, twice daily treatment for

1 nineteen treatments.

2 And another example. Patient received a dose
3 delivered to the wrong site. Patient received
4 treatment to incorrect area of the spine. And the
5 error was discovered after one treatment and
6 corrected.

7 So any questions on medical events?

8 RANDY SCHENKMAN, CHAIRPERSON: who has to report
9 them and how do you -- how do we know that they're
10 actually being reported? All the events?

11 LISA GAVATHAS: We don't. And most events
12 probably are not reported. I think there's been
13 some studies with, I'm not sure what governing body,
14 but they say that less than eight percent of medical
15 events are actually reported. And I think -- that
16 was told second hand to me, so I'm not exactly sure
17 if that's true or not, but I do think that there's a
18 low number.

19 The problem comes is that we don't have a
20 specific definition of a medical event. And I know
21 that was discussed during the last advisory council
22 meeting as well. We've been working on that. There
23 is a handout with some proposed language changes in,
24 in the handout. However, there are some other,
25 other outlying factors that I think need to be

1 addressed as well because of technology changes and
2 what have you.

3 But what we're doing is just trying to put
4 something out there saying we are looking for input.
5 We are requesting any information that would help us
6 try to define what a medical event is. Because if
7 you have -- because, like, a medical physicist has
8 called before and said, I'm reporting a medical
9 event. However, I don't really know if it is one or
10 not. So it's -- then we have to determine is it a
11 medical event? Because they say, okay, what if it
12 was a geometric miss? What if it was this, what if
13 it was that? So these are things that we also have
14 to take into consideration.

15 So, Cindy, do you have something to add with
16 this?

17 CYNTHIA BECKER: Just that it's the very early
18 phases of us trying to collect information from
19 different sources. You know, we have the AAPM, we
20 have Astro, we have our contacts that we have
21 throughout you all, plus all the other associations
22 that are out there. And other states, you know,
23 have been involved with this for a very long time.
24 And as soon as you start to get close to it, then,
25 of course, technology changes. So any help you can

1 provide, any places you can direct us to go search
2 for more, more answers, we'd be very appreciative
3 of that.

4 JAMES FUTCH: I think if you look in the
5 pamphlet on -- it looks like, the pages look like
6 this if you haven't found it already. I think what
7 Lisa meant was there's actually a couple, a couple
8 different kinds of definitions of what constitutes a
9 medical event. And from my experience dealing with
10 the technologist, the operator side of it, it's kind
11 of like which one of these holes do I fit into or
12 does it fit into any of these holes -- particular
13 categories.

14 The first couple I think are not, not as
15 difficult to understand. You know, if you look at
16 85(c)(1), something that results or will result in
17 permanent functional damage to individual's organ or
18 physiological as determined by a physician. well,
19 we've been involved in scads of these over the
20 decades and I can't think of one where a physician
21 actually said that, had that level of damage. I
22 don't know if that didn't happen, but they certainly
23 haven't really, you know, gone overboard in
24 reporting those.

25 The next two are the most, I think, common and

1 the easier to understand. You got the wrong person.
2 You know, pulled up completely wrong treatment chart
3 for Mr. Smith and you gave it to Mr. Jones. Maybe
4 it was the same part of the body. Probably was.
5 Something along those lines.

6 But the next one, three there, wrong treatment,
7 wrong mode of treatment, wrong treatment, wrong
8 treatment site. That treatment site business I
9 think is what gives rise to much of what the
10 proposed language -- or not the proposed language --
11 much of the focus is on treatment site. And the
12 rest of them get very specific, you know. Is it
13 treatment that consisted of different
14 qualifications, three fewer refractions and the
15 total administered dose was different than the total
16 prescribed more than ten percent. Now we're into
17 percentages.

18 why ten percent? The governing standard body,
19 whoever it was that was the original architect of
20 all this, probably put in some sort of, well, ten
21 percent is, you know, we're not always exactly on
22 target, so ten percent maybe more than that is the,
23 is the way to go about it.

24 And then you start getting into the
25 administrative weekly dose, is thirty percent

1 greater or it differs from the prescribed by more
2 than twenty percent overall.

3 And then in Part 16, which I had something to
4 do with a number of years ago, for this particular
5 kind of therapy, which is the electronic
6 brachytherapy, we kind of winnowed it down to kind
7 of a, a more, I think, understandable, at least at
8 that point in time for that particular kind of
9 device, set of categories.

10 And then the rest of it, you see from there to
11 the next page is, I believe Clark, who is Lisa's
12 supervisor who is the architect of all this, I think
13 what he was going for was to try and tackle, you see
14 there's no changes to one through three for medical
15 event. Is trying to tackle some of the other stuff
16 about and provide a definition of what treatment
17 site is.

18 I don't know if it does it and we're not saying
19 we're going forward with any rule making. We're
20 really just throwing something out, or Clark is
21 throwing something out there for discussion and for
22 anyone to, you know, say, well, yes, we don't
23 believe him, for example, is working on something
24 new or we find this to be useful at our facility.

25 But I think it would -- the idea was trying to

1 figure out how close is close enough if you're
2 talking about you're off by a little bit on your
3 treatment site.

4 Now, treatment site, oh, treated the left leg
5 instead of the right leg. That's pretty
6 understandable, right? You know. Okay. I'm in the
7 spine and I treated a thoracic vertebrae instead of
8 lumbar. Okay. That's pretty much understandable.
9 Wrong treatment site.

10 what if it's the exact target volume but you're
11 slightly, you're slightly off? You know, you got
12 ninety-five percent of what you were trying to do
13 and you hit five percent or fifteen percent of more
14 healthy tissue than you intended. Is that a medical
15 event? That's my sense of where this is coming
16 from.

17 LISA GAVATHAS: Is there a critical structure
18 right there in that area or is it a re-treat. Like
19 if that area's been treated previously, then that
20 becomes a concern. So that's where we are on that.

21 JAMES FUTCH: So unfortunately, Doctor Williams
22 is not here, but Kathy and Mark are here. And
23 anybody else who wants to weigh in.

24 MARK SEDDON: I think for, for event reporting,
25 I think you may see more of the -- I'm not sure

1 about medical event or not, I don't want to be first
2 to say safe to let you know so we can do a full
3 investigation. If it was not as punitive and more
4 of an informative, corrective action, let's make
5 sure the patient is safe, let's make sure we've
6 corrected it any processes at the facility, that
7 would be more effective in improving your reportable
8 rate. Because people would be more willing --

9 LISA GAVATHAS: I agree.

10 LYNN ANDRESEN: I agree.

11 MARK SEDDON: -- to go ahead and contact the
12 state to have, to have the process looked at.

13 One of the -- at a national level, one of the
14 things that was created was the ROILS, which is the
15 Radiation Oncology Information Learning System,
16 because as you say, errors in radiation oncology
17 were frequently underreported because people were
18 afraid of, you know, to types of actions and/or they
19 didn't quite understand the results of the no
20 harm/no foul kind of, you know, thinking as well.
21 It was like, well, I mean, the patient has got
22 cancer. We just gave it treatment to an area that
23 now they say, I'm going to treat that other area. A
24 lot of it is based on their judgment, how they're
25 going to treat.

1 Technology changes where, you know, twenty
2 years ago, we were treating very broad sections of
3 tissue. Now we're treating very fine, tiny little
4 structures. So we're really defining our PTV to a
5 very small area, which in the past, we would include
6 the whole section of tissue. I think that also
7 makes a, makes a different -- difference as well.

8 But the, like the ROILS was created to allow a
9 process for studies to report to a patient safety
10 organization, errors in radiation oncology they can
11 frequently report anonymously and in effect,
12 everyone else can learn from it, other facilities
13 around the country can learn from it, to learn
14 what's really happening out there. What are the
15 errors that are occurring that may not qualify as
16 medical events under some definitions or maybe are
17 not being interpreted as medical events as the
18 current regulation's applied in that specific state.

19 So that would probably help. I think in
20 Florida, if you think our reporting is too low,
21 because I know I've heard anecdotally there's some
22 concerns from folks that it was a, you know, a minor
23 error what they thought and then they thought there
24 was a very rather heavy-handed approach to the
25 inspections.

1 So I've never experienced that, but I've heard
2 that. That sometimes can be, especially when you
3 have the three, like you have the MqA folks come out
4 and look at the potential effect on licenses or the
5 individuals as well, so that's a concern for
6 individuals not to report, and that they may feel, I
7 don't want to, you know -- because the medical
8 physicist reports it to the state, the therapists
9 are the ones actually reported to the medical
10 physicists.

11 LISA GAVATHAS: Right.

12 MARK SEDDON: So if they know that when they
13 have an error, they reported it to their boss, to
14 report to the state, they're not going to want to
15 report that because they're going to lose their
16 license or be fined.

17 KATHY DROTAR: Or lose their job.

18 MARK SEDDON: Or lose their job. Hospitals
19 already have that in place. If there's a patient
20 error, you're not, you're not going to lose your job
21 over a patient error. Patient error, you have to
22 report it, and they want to encourage reporting. So
23 risk management system, that's one of the things
24 that the -- they are not to have any disciplinary
25 action against you for errors like that.

1 Now, repeat errors and not following policies
2 and procedures, that's one thing. But if you, if
3 you come across an error that occurs and, you know,
4 the expectation is you report it. That's more
5 important. The first thing is patient care.

6 LISA GAVATHAS: Right.

7 KATHY DROTAR: And I think just having a place
8 that you can call and say, most radiation physicists
9 and radiation oncologists are -- want to hear what,
10 what you've seen that day or if there's something
11 that occurred that maybe you have a question about,
12 but not everybody is, and so I think, you know, if
13 you've got a question, can you -- is there a place
14 that you can go to to say, I think this needs to be
15 checked. Or if you're seeing things that maybe
16 aren't quite what you think they should be so that
17 you can, you know, and as you said, define that, no,
18 this is acceptable limits. Because I don't think we
19 really have anything except for broad based, you
20 know, this is, this is going to impact on the
21 patient.

22 But, you know, if you're -- the one you talked
23 about with, if you're not centered where you're
24 supposed to be centered on the spine but maybe
25 you're a little bit to the right but there aren't

1 any critical organs there, but if you -- if you're
2 higher in the thoracic spine and go to a little bit
3 to the left, then you've got lung and heart in
4 there. And then that becomes that, that reportable,
5 you know.

6 And making, making people not afraid to report,
7 I think is, and having maybe some kind of a database
8 that might give you numbers that you could talk to
9 somebody about that would be anonymous, that you
10 would get more of that information. Because I think
11 as therapists and -- that if you see something
12 that's not right, your training is to say something
13 to somebody. And the only thing that really holds
14 you back is, what are they going to say to me? And,
15 you know, the response should be, well, if there's
16 anything wrong, thank you for telling us so that we
17 can report it and we can, we can take care of the
18 patient and do what's right by the patient.

19 MARK SEDDON: Because I think the majority, in
20 85, the majority of the, of the items listed are,
21 you know, the bigger items and they are
22 definitely -- if you have wrong patient, wrong site,
23 I mean, the wrong dose, you know, substantial, then
24 those are reported because people know it's a big
25 mistake.

1 It's like if a painter paints the room a wrong
2 color, well, everyone notices it. If you, like,
3 maybe along the edges, they're going outside the
4 lines a little bit along the ceiling, well, you
5 know, that becomes is it acceptable or not
6 acceptable by the individuals.

7 That's, I think, where we have, you know, some
8 confusion. The wrong site is what you're talking
9 about is -- if you're painting a whole wall, it's
10 not a big deal. If you're painting up there, it's
11 tight, it becomes important.

12 So the majority of those types of errors are
13 caught by the therapists.

14 LISA GAVATHAS: Right.

15 MARK SEDDON: Wrong site, wrong location, that's
16 the therapist. That's why if we have a
17 less-punitive reporting process or an investigation
18 process for those, we'd probably see improved
19 reporting. And then if they're reporting them, we
20 can see where -- what is the cause of those errors?
21 what's causing the shifts that are not being caught?
22 what's causing the variations in, in set up every
23 single time, every infraction, and then that could
24 be worked on.

25 Because that's really what has been happening.

1 People turning a blind eye to it so no one is
2 looking at fixing that specific part of the
3 treatment process.

4 Lots of checks and balances then for dosimetry
5 and for prescriptions. Not a lot of checks and
6 balances in for --

7 RANDY SCHENKMAN, CHAIRPERSON: Location.

8 CHANTEL CORBETT: I don't know. It may be an
9 option, too, like, three people from a higher agency
10 walking in as a group is probably very intimidating
11 to most people. So I don't know if there's maybe,
12 like, an option for a staged investigation, where
13 one individual would come in and gather the majority
14 of the data, and then, if necessary, elevate it and
15 bring in additional people.

16 Because I know in some of our accrediting
17 bodies, if one person walks in for an inspection or
18 something, it doesn't cause much ruckus, let's say.
19 If you have three people walk in, then everybody
20 kind of goes on high alert. Everybody is a little
21 more panicked. Everybody is a little more, you
22 know, uptight about everything and it makes
23 everybody real nervous. So I don't know if that's
24 an option, too.

25 LISA GAVATHAS: Right. And MqA kind of

1 addresses that in the investigator training as well.
2 It's like, if you're interviewing one on one, you
3 should be one on one. You should have -- if there's
4 more than one person in there, you should be face to
5 face with that person. The other people are -- if
6 there's someone else in the room, they should just
7 be taking notes and that sort of thing.

8 CHANTEL CORBETT: And I don't know if that
9 would make me less nervous with two other people
10 taking notes and one person talking to me.

11 MARK SEDDON: I think you do an affidavit. I
12 think the people involved, they have to do something
13 like a signed affidavit. It seems very formal. So
14 I think that's what scares a lot of the -- usually
15 most of our therapists have, you know, they are
16 crying afterwards and they are not happy.

17 LISA GAVATHAS: For MqA, they do have to do the
18 affidavit. For the state, as far as we're
19 concerned, it's not an affidavit. It's just a
20 statement of what happened.

21 MARK SEDDON: Right.

22 LISA GAVATHAS: But they do have to sign it.

23 RANDY SCHENKMAN, CHAIRPERSON: But I think that
24 most of the techs are very concerned about the
25 repercussions of --

1 LISA GAVATHAS: Yes.

2 RANDY SCHENKMAN, CHAIRPERSON: -- of doing that.
3 And there are repercussions usually within the
4 department, within all kinds of things. So --

5 LISA GAVATHAS: And we have been asked by
6 physicists, please make this nonpunitive,
7 specifically.

8 JAMES FUTCH: Yeah. Speaking as the guy who
9 determines probable cause against the operators, and
10 it being recorded, there are a set of guidelines in
11 the statute and the regulations that are mitigating
12 or aggravating circumstances. It's obvious things.
13 Repetition is an aggravating circumstance; you know,
14 things of this nature.

15 From my perspective, the don't be so punitive,
16 I think, is an outgrowth of, at least in part, the
17 number of events that kind of mushroomed on us all
18 in one particular fiscal year. Traditionally, you
19 guys have been, and for a little while, may remember
20 Don Steiner or Tom Tomcheck, two of the folks in the
21 program, x-ray program before Lisa, would go to the
22 annual AAPM meetings and give an update on all the
23 medical events that had happened in past years.
24 Sort of like what Lynn did, perhaps with a
25 paragraph. You do that often enough, you see the

1 same things over and over. It kind of looks like,
2 ten years, we're still doing the same thing. Same
3 things are happening.

4 But the number was not huge. It was per year,
5 on the order of a couple, two, three. And then in
6 one particular fiscal year, not too long ago, it was
7 seventeen or eighteen. Just happened all in one
8 year. And I think there was some discussions about
9 is the state becoming, you know, overly regulatory
10 or in particular, the Bureau of Radiation Control.
11 And it really had absolutely nothing to do with us
12 becoming overly regulatory or punitive or anything
13 like that. It was just they all happened. Some
14 physicists at some facility called us about every
15 single one and prompted and said, we had this
16 happen. But then we, you know, we had to deal with
17 that. Because it kind of like, look, these guys are
18 going out twice a month now, different parts of
19 Florida, and all these different things are
20 happening.

21 Really, I don't think changing, at least from
22 my perspective on the operator's side, didn't really
23 change anything in terms of what we were doing.

24 And so I wanted to throw that out as historical
25 background. I think we're at, for whatever reason,

1 somebody turned off the medical event machine and
2 we're back to, like, a couple, two, three, a year
3 now.

4 BILL ATHERTON: That was my question. Those
5 three or four events you said were all events you
6 had this year or what time frame?

7 LYNN ANDRESEN: No. They are just past,
8 examples of past. I just wanted to share.

9 JAMES FUTCH: But the numbers are back to
10 historical averages.

11 BILL ATHERTON: Which are two or three?

12 LYNN ANDRESEN: Two or three a year.

13 RANDY SCHENKMAN, CHAIRPERSON: But that's the
14 ones that are reported.

15 JAMES FUTCH: Yeah. Comparing apples to apples.

16 CHANTEL CORBETT: If you get people to start
17 reporting them all in one year, then you're going to
18 see that kind of, like, high alert level, everybody
19 nervous kind of thing.

20 MARK SEDDON: About ten years ago, I was on the
21 National Board at that time, and people were coming
22 out and testifying in front of Congress and there
23 was a national initiative for patient safety in
24 radiation oncology. A number of different things
25 came out.

1 So that may have correlated to your increase in
2 reporting, because it raised awareness, too, across
3 the industry.

4 JAMES FUTCH: I would love to know what caused
5 it. Something in the water that year. I don't
6 know.

7 CHANTEL CORBETT: I mean, if your average is two
8 or three, and you go to fifteen, obviously, it's a
9 huge growth percentage. But it's, you know, it's
10 all relative.

11 JAMES FUTCH: Yeah. It's really small --

12 CHANTEL CORBETT: I mean, you know. It's one
13 of those things, you're penalizing and the end is
14 probably no different. But individually --

15 JAMES FUTCH: To the industry, though, there's
16 not a huge number of facilities. There's even a
17 smaller number of medical physicists dealing with
18 all of it, going to meetings and talking about it.

19 CHANTEL CORBETT: Right.

20 JAMES FUTCH: So fifteen, seventeen, eighteen
21 looks like a bunch --

22 CHANTEL CORBETT: Right.

23 JAMES FUTCH: -- at that particular meeting.

24 CYNTHIA BECKER: How about the number of
25 therapies being done, treatments also increased. So

1 could it be just that especially in Florida, being
2 who we are here with the retirees and such, that
3 there is more treatments being done and then also,
4 the technology advances, you're going to have more,
5 more errors, or are they really, like we said,
6 medical events or not. Because now we're just fine
7 tuning, like Mark had said, we're getting really
8 close to just pinpointing and targeting the actual
9 tumor whereas in the past, everything that would've
10 been done would've been considered, in today's
11 terms, as medical events.

12 MARK SEDDON: Right. And we --

13 CYNTHIA BECKER: Just like before we had the
14 old, we didn't have dedicated mammography x-ray
15 units. We had just a cone that was attached. And
16 that was part of the BENT program back then. So I
17 think a lot of it is technology.

18 MARK SEDDON: So it may require some redefining
19 of the definitions, like you said. That's what you
20 guys are doing.

21 CYNTHIA BECKER: Right.

22 JAMES FUTCH: In doing that, we historically
23 have looked to national standards or standards of
24 relevant organizations, professional societies
25 involved. So we really don't like to recreate, you

1 know, the wheel for new things. It's also much
2 harder to defend it when it gets into a hearing if
3 it's something we just thought of in Florida and
4 nobody else is doing it.

5 MARK SEDDON: Didn't the NRC, the ACMUI, didn't
6 they just have this discussion just two months ago
7 at the National, at the --

8 JAMES FUTCH: I wish I could tell you. Not
9 being the author of that particular piece, that
10 could be something that caused Clark to --

11 MARK SEDDON: They had a likely discussion and
12 some presentations, whoever was the advisory person
13 at that task group that worked on revising medical
14 events, I think they basically came up with, they --
15 his recommendation was not to more closely define it
16 because they want to keep it opened ended for
17 changing technology and for just to --

18 JAMES FUTCH: Open. I can see that.

19 MARK SEDDON: -- to allow for the cause, I'm not
20 sure this is the event or not. So what do you guys
21 think?

22 CYNTHIA BECKER: That was NRC, ACMUI, were they
23 focused just on materials?

24 MARK SEDDON: Yeah. They were looking at
25 materials. And so, they were looking at materials.

1 JAMES FUTCH: And that's, I think, another
2 aspect of this that maybe not everyone is aware of
3 is that a lot of this, we as an agreement state in
4 regulating through the transferred authority of the
5 Nuclear Regulatory Commission, have to follow fairly
6 closely what they put forth as a recommended
7 regulation. We -- that's not true when it comes to
8 machine-based therapies. We've, I believe, always
9 had the opinion that it's radiation. We really
10 should be agnostic in terms of the source of the
11 radiation and not apply one set of standards because
12 it came from materials and another because it came
13 from a device you plug into the wall.

14 But that also means we don't have a, I guess an
15 FDA or another group out there on the machine side
16 that's saying, this is what a medical event is, we
17 need to comply with it.

18 MARK SEDDON: NRC PD has --

19 JAMES FUTCH: Has some state regulations.

20 MARK SEDDON: You were at the last meeting.

21 CYNTHIA BECKER: Yes, and there were several
22 discussions involved in that. And I'm going to the
23 CRCPD board meeting in October and AAPM will be
24 represented there as well as FDA, EPA and DOE and
25 all the others and I know that that is something

1 that's probably going to come up again. So I intend
2 to kind of make use of the contacts there to say,
3 you know, help us with this.

4 MARK SEDDON: Within AAPM nationally, it's like
5 Lynn Farvin and those folks are working hard on
6 trying to respond to requests for information.

7 CYNTHIA BECKER: Melissa Martin and Kate Hitlang
8 (ph), I usually see them. I hope to see them in
9 October. So, but, yeah, CRCPD is a great
10 organization as far as getting involved with the
11 state programs and seeing what other states are
12 doing and kind of trying to make it consistent
13 throughout the United States and really throughout
14 the world, but that gets even harder.

15 MARK SEDDON: Yeah.

16 CYNTHIA BECKER: So --

17 JAMES FUTCH: And so, one more aspect of this
18 that I wanted to bring out. When the team goes out,
19 it's -- one of the reasons it's not just one person
20 is because it's a very complex subject from the
21 standpoint of oncology in general and then the
22 machine and the physics side of it. And then the
23 operator, all the different, you know, there's the
24 dosimetrist, there's the microphysicist, there's the
25 oncologist, there's the therapist side of it. So

1 it's very hard to find one person to kind of cover
2 all that, so we ended up with a team approach.

3 But what, what they generate is basically an
4 investigative report. And then it, and then it goes
5 to the, the x-raying section for workup into, what
6 are you going to do with that? Does this meet the
7 definition for a violation of any of the different
8 types of violations you've got established? That's
9 a decision for my counterpart, Clark Eldridge and
10 Bureau chief.

11 After all that's done, the output of all of
12 that, that report especially, and then we typically
13 wait until the machine program has determined what
14 they're going to do, because we don't want to get in
15 the middle of it on the, the operator side. We'll
16 take all the material and then just look at it from
17 just the operator perspective. When I say operator
18 perspective, I don't necessarily mean just the
19 radiation therapists. There are several licensed
20 professions that are involved in this. There's the
21 physician as well as the medical physicist, as well
22 as the operators.

23 The one profession that's not, of course, is
24 the medical dosimetrist, which is not licensed in
25 the State of Florida. So if the therapist didn't

1 follow procedures or was guilty of negligence or it
2 appears was guilty of negligence, there's really no
3 recourse at the state level for us to do anything
4 with that.

5 However, all the other total package of folks
6 who were involved in this particular range of
7 events, could be multiple therapists, usually at
8 least two, sometimes if it's multiple infractions, a
9 lot more than two, we'll look at that. And then
10 there are parts of, at least the area we're
11 responsible for, the technologist's side of it,
12 we'll look at it and look against those mitigating
13 and aggravating circumstances and at least, actually
14 before you even get there, just determine whether or
15 not there is a rule or a regulation that appears to
16 have been violated. And then we'll package that up
17 and send it over to the prosecutors to look at.

18 They don't always do anything with it. They
19 may think that it is not, in fact, something that
20 rises to the level of really violating that, that
21 rule and that statute. If they do, they will bring
22 it back and they will present it and say, is this,
23 is this evidence or not. We'll say yes or no and
24 then leave. It's out of our hands at that point.
25 It goes back to the prosecutors and they, they

1 determine penalty.

2 It could be a letter of guidance, which is a
3 non-disciplinary type of event. We're basically
4 saying, just maybe messed up one time, they didn't
5 really harm the patient, and they will write a
6 letter that says, hey, this is a violation. Don't
7 do this again. Here's the statute. Here's the
8 regulation. Or it could be a whole range of things
9 everybody thinks about, a reprimand, a fine,
10 suspension or revocation. Rarely, if ever, is this
11 ever going to end up being a suspension or an
12 revocation. It's usually a letter of guidance and
13 reprimand or fine.

14 And they will take the aggravating and
15 mitigating circumstances into account.

16 RANDY SCHENKMAN, CHAIRPERSON: But --

17 JAMES FUTCH: Not just --

18 RANDY SCHENKMAN, CHAIRPERSON: -- but the point
19 that's been brought up is because of that potential,
20 people don't want to put themselves --

21 JAMES FUTCH: I understand.

22 RANDY SCHENKMAN, CHAIRPERSON: -- or other
23 people that they are associated with in that
24 position.

25 JAMES FUTCH: Agreed. I understand that. I've

1 found it quite difficult to -- making a
2 determination one way or another, is hard enough.
3 Developing a policy or an inclination that says,
4 well, that's just a mistake, you know. That's not
5 something that we need to follow through on the
6 process with that. That kind of puts you in a very
7 dangerous spot. The folks on the front end just
8 think, does the inspector do that? Does the Bureau
9 chief do that? Do I do that? I would prefer
10 people, you know, report what they want to report
11 and we'll deal with it. And we'll make an honest
12 determination, just like we do everything else. I
13 don't think their reputation will bear out that
14 we're, you know, like certain other, perhaps
15 regulatory agencies that people can think of. I
16 won't name them.

17 CYNTHIA BECKER: You won't name them?

18 JAMES FUTCH: Yeah. That you trying to screw
19 you to the wall, so to speak.

20 RANDY SCHENKMAN, CHAIRPERSON: well, maybe
21 there's a way to find a happy medium. You know?

22 LISA GAVATHAS: That would be good.

23 RANDY SCHENKMAN, CHAIRPERSON: I think that's
24 what it looks like it's boiling down to. So that
25 you get the reports and can see what's going on or

1 at least the questions, but, you know, people won't
2 do that if they think they're going to be punished
3 or they're going to be fired.

4 CHANTEL CORBETT: Unfortunately, I don't think
5 the firing part of it, I don't think the state's
6 going to have any control over. Obviously, that's
7 going to be an institution thing.

8 JAMES FUTCH: It probably happened already if
9 they thought it was. And I would like to say the
10 flip side of this is, there are places that do have
11 repeat violations. Facilities have repeat
12 violations. Kind of more so probably than the
13 individual operators.

14 MARK SEDDON: And that's where you want to
15 report those because that means it's a process
16 problem at that facility and you want that process
17 to be addressed.

18 JAMES FUTCH: Yeah. And then there are
19 instances in the past that one can think of that
20 are, you really would like to find some regulatory
21 mechanism to, quote, "make things better", and there
22 isn't one. And the place just goes on with bad
23 management and frequent changes of personnel. And
24 the new person on the block is astounded they are
25 doing these things. So you get another report; so

1 forth.

2 CYNTHIA BECKER: That fine line of trying to be
3 a regulatory body, at the same time an educational
4 one. It would be much nicer just to be an
5 educational one.

6 JAMES FUTCH: You know what our attorneys tell
7 us, right?

8 CYNTHIA BECKER: I know what they tell us.

9 JAMES FUTCH: We're not consultants and
10 educators.

11 CYNTHIA BECKER: We're not consultants. We
12 can't give opinions.

13 RANDY SCHENKMAN, CHAIRPERSON: But that may be a
14 way to get around this, is that if there are
15 reports, particularly repetitive ones, then in order
16 for those people to keep their license, they need to
17 have extra education and they need to prove to the
18 state that they've had it.

19 CYNTHIA BECKER: That would be --

20 JAMES FUTCH: That's good.

21 CYNTHIA BECKER: That would be a nice thing to
22 put in there, wouldn't it?

23 CHANTEL CORBETT: Like a probationary period.

24 RANDY SCHENKMAN, CHAIRPERSON: Yeah. Something
25 along those lines. In order to correct the problem.

1 But still have people want to report it.

2 KATHY DROTAR: I think it's not a generally
3 known -- it's not generally known that, that each,
4 each incident would get looked at independently and
5 stand on its own merit or not. So that it's not
6 necessarily something that is punitive or considered
7 punitive. Because like you keep saying, it may or
8 may not be and you have to look at the situation to
9 determine what you're going to do and it's not just
10 therapy. We just have bigger numbers in therapy, so
11 it's more evident there's going to be some impact on
12 the patient. But it happens with CT, with nuke med,
13 with any of those, any of -- and technologies that
14 we haven't used yet. So --

15 KATHY DROTAR: Back to square one.

16 CYNTHIA BECKER: Back to square one.

17 RANDY SCHENKMAN, CHAIRPERSON: Okay. Anybody
18 have anything else on this topic or --

19 BILL ATHERTON: One quick, on just these
20 numbers. I noticed that the, in the top, the number
21 third most numerous radiation facility is
22 veterinary. Is that one of the groups to have a
23 representative of them on this council or not or is
24 that not -- is that not necessary?

25 JAMES FUTCH: Yes. So the.

1 BILL ATHERTON: I mean, obviously, there's no
2 people involved really, except for the people taking
3 the x-rays are just a few.

4 CHANTEL CORBETT: Or giving iodine in the case
5 of cats. which is like the number one user, I
6 believe, in Florida.

7 JAMES FUTCH: Right. So, yeah. If you look at
8 the breakdown of facility types, either by tubes or
9 by machines, the dentists are way out in front.
10 They won the war, I guess, on that one.

11 (Laughter)

12 JAMES FUTCH: 32,000 tubes.

13 ADAM WEAVER: Little less expensive.

14 JAMES FUTCH: In terms of the make up of the
15 council, that's one of the things that's hard coded
16 into the law. It's in the statute. Actually, it's
17 in -- not Chapter 404, where the authority for the
18 registration, inspection of machines and materials
19 is, but it's in the Rad Tech certification statute,
20 which is why we have a lot of medical folks on this
21 particular group.

22 Point taken. Out of our control.

23 BILL ATHERTON: That's fine. It's just a
24 question.

25 JAMES FUTCH: Legislator kind of matter. But,

1 yeah, we've heard, heard that. Also with the
2 cardiologists, I think we talked about once before,
3 right?

4 CYNTHIA BECKER: Yeah.

5 JAMES FUTCH: The best way for that to happen
6 actually, come to think of it, is we have two, two
7 positions on the council.

8 RANDY SCHENKMAN, CHAIRPERSON: Lay person
9 positions.

10 JAMES FUTCH: Lay persons. And Dr. Cогnetta
11 actually is in one of them right now. So when
12 either of those become available next time, that's a
13 possible. It just has to be somebody who's not in
14 one of the licensed radiation professions or
15 something closely related to that. So a
16 cardiologist or veterinarian, I think would work.
17 So that's a nonstatutory change way of trying to do
18 it.

19 RANDY SCHENKMAN, CHAIRPERSON: Right.

20 JAMES FUTCH: Statutory changes are few and far
21 between.

22 RANDY SCHENKMAN, CHAIRPERSON: Okay. Anybody
23 else with any comments?

24 I guess it's lunchtime.

25 JAMES FUTCH: And we're going to come back

1 at --

2 RANDY SCHENKMAN, CHAIRPERSON: 1:30.

3 JAMES FUTCH: I think we have lunch ready out
4 there?

5 BRENDA ANDREWS: Yes.

6 RANDY SCHENKMAN, CHAIRPERSON: Is that good for
7 everybody, 1:30?

8 (Proceedings recessed at 11:38 a.m.)

9 (Proceedings resumed at 1:00 p.m.)

10 (Mark wroblewski and Keith Nadaskay
11 are not in attendance)

12 RANDY SCHENKMAN, CHAIRPERSON: So welcome back,
13 everybody. We are now going to turn it over to
14 James, as soon as he's ready.

15 JAMES FUTCH: As soon as he's ready, yes.

16 RANDY SCHENKMAN, CHAIRPERSON: This is the
17 Radiologic Technology Update.

18 CYNTHIA BECKER: Is that what it is?

19 JAMES FUTCH: Very specific.

20 CHANTEL CORBETT: Nothing new. Always a
21 troublemaker.

22 JAMES FUTCH: Okay. So we have an issue that
23 we talked about, we have an issue and Chantel's
24 related to it. No, Chantel, of course, is the
25 nuclear medicine technology position, so she's been

1 the focus of -- and her predecessor, of several
2 communications from the Society of Nuclear Medicine
3 and NMTCB starting back in 2015.

4 So you may recall, right now in Florida, we
5 have what we call specialty technologists and these
6 are new categories of certification that were added
7 after the law was changed in 2012. Prior to that,
8 we had three primary types of certification:
9 Nuclear medicine, general radiography and radiation
10 therapy. And then we had the limited scope or the
11 basic as we called it in Florida. That was in the
12 statute from '78 to '84, '84 onward.

13 So in 2012, we were dealing with the inability
14 to add any other kinds of certification without
15 having to go back and change the statute and we had
16 actually been trying, through assistance with
17 different organizations, to get the law changed back
18 in -- Cindy, you can tell me.

19 CYNTHIA BECKER: No, it's like, how long ago.

20 JAMES FUTCH: Just hit me in the back of the
21 head if I say something wrong.

22 So we had been trying to add some new kinds of
23 certification in Florida, and one of the kinds of
24 certification that we were trying to add was the CT
25 technologist. And that was partly because of fusion

1 imaging. Starting in '97, '98, '99, they started in
2 the industry fusing x-ray images in various forms
3 and ways with nuclear medicine images. And when the
4 societies finally decided to open up the CT
5 technologist certification and the PET
6 certification, ARRT for the CT exam, NMTCB with the
7 new PET exam, two folks from different primary
8 areas, that was supposed to kind of solve the
9 problem. A lot of nuclear medicine technologists
10 went to ARRT and got CT certified.

11 And that worked for a number of years. We had
12 the scope of practice change from nuclear medicine
13 to allow fusion imaging to work, wherein the nuclear
14 medicine tech could do a limited form of CT.

15 But after they had gone to ARRT and got fully
16 certified in, shall call it, freestanding diagnostic
17 radiology kind of CT, they wanted to be able to use
18 that in Florida and we had no way to allow that to
19 happen. So the 2012 law was passed. And it gave us
20 the ability to add other kinds of certification
21 through rule making, without having to go back to
22 the Legislature. And we did. We added CT, we added
23 mammo, we added PET and added MRI and then pulled
24 that back a few years later.

25 And in doing that, the only CT registry that

1 was in existence, at that point in time, was ARRT.

2 So right now, just to give you some, let's
3 see, approximate numbers, there's, I think, about
4 175 CT techs licensed in Florida. To give you a
5 comparison, 400 something mammo techs; six PET
6 technologists. Now, these are Florida certified,
7 Florida licensed folks.

8 At the national registry levels, there are a
9 lot more, of course, than that. CT and mammo are
10 very popular with ARRT. There's thousands and
11 thousands of CT techs.

12 But what happened in 2015 which gave rise to
13 this discussion, many of you were part of the
14 council back then. This discussion, you'll see in
15 the minutes from the May 2015 meeting, is when NMTCB
16 came back and created their own CT registry.

17 So at that point, I think they had had a few,
18 a few people go through, like, 100 or 200 CT techs,
19 that had gone through this brand new certification
20 and become certified by NMTCB to do CT. Any kind of
21 CT, not fusion imaging CT.

22 And so, now we have two different registries,
23 but our Florida regulations are written so that only
24 the people from the, pardon me, only the
25 technologists nationally certified by ARRT, NCT,

1 could become licensed in Florida to do CT.

2 okay. So this is, this is Cybil Nielsen, who
3 was with us at that point, representing NMTCB -- she
4 was a board member -- in describing all of the
5 things that go into what it takes to become
6 certified through NMTCB to do CT. There's 40 pages
7 of this. We talked about this for a long time.

8 Alberto had some comments in here; Tim
9 Williams, who is not with us, Becky McFadden, who's
10 not here, is in his position; Kathy had a bunch of
11 comments. Lots and lots of discussion back and
12 forth. I'll save you the trouble because I read all
13 this last night again.

14 NMTCB has, at this point in time, 2015,
15 according to Cybil, Arizona and Oregon were in the
16 process of accepting NMTCB certified techs into
17 practice in those states. At this point in time,
18 the Joint Commission was recalibrating to recognize
19 this particular kind of alternative CT. So Cybil
20 spent pages and pages and pages explaining the
21 difference between and the reasons behind why they
22 had a registry in addition to ARRT that goes
23 something like this:

24 ARRT's mechanisms for becoming certified in
25 CT -- both of these, by the way, are what you would

1 call post primary; so therefore, these folks are not
2 going back to a traditional classroom educational
3 program necessarily to become qualified to sit for
4 either one of the exams.

5 The biggest difference is ARRT -- and this is
6 still -- I reread the qualification requirements
7 also -- this is still pretty much the same, as far
8 as I can tell. To become able to sit for the CT
9 exam for ARRT, you have to do a certain number of,
10 call them didactic hours, in different -- the
11 appropriate subjects that you would think of for CT,
12 as well as perform a certain number of exams from a
13 certain number of different kinds of CT imaging.
14 And the number, I think, is five areas out of seven.

15 KATHY DROTAR: 125.

16 JAMES FUTCH: Five of each, for a total of 125
17 exams. But the bottom line is you have to do a
18 certain number of procedures; has to be signed off
19 on; has to be proven. All the rest of this kind of
20 stuff. And then they sit and take a very
21 comprehensive CT examination.

22 So all of the nuclear med techs who wanted to
23 become CT's prior to the NMTCB certification for CT
24 starting, did this. And there was some issues with
25 that, which we talked about extensively, which is

1 this, this kind of hard-and-fast number of exams in
2 different areas.


3 And NMTCB's philosophy, as described in these
4 minutes, please go read them yourself in your
5 leisure time, was different. They don't want to
6 specify a certain fixed number of exams in different
7 kind of areas. They have a certain number of hours
8 of experience in doing all forms of CT that they
9 require. And it's 500 hours is what they require.
10 And their didactic course work is, I think, 35
11 contact hours on top of that.

12 These days, since 2011, a lot of this can be
13 accomplished actually in the nuclear medicine
14 educational program, because the curriculum
15 standards have been recalibrated for the JRC and MT
16 accredited schools, which is all, as of 2016, NMTCB
17 accepts anymore. To incorporate CT into the base
18 curriculum.

19 So a lot of that experience that they need,
20 those 500 hours, if it's accomplished within three
21 years of applying for the CT and sitting for the CT
22 exam, you can count some of that. You can count
23 some of your school work if your school work
24 happened to cover CT.

25 There was a lot of back and forth; Alberto,

1 you had a whole bunch of questions; Kathy, you had a
2 whole bunch of questions; other folks, really, we
3 picked this thing apart. We didn't mean to be. We
4 were trying to understand all the different aspects
5 of what it would take before we accepted another
6 national registry into Florida certification for CT.

7 And what it came down to was mostly that there
8 wasn't a practice standard specific to CT for the
9  MNTCB-CT persons.

10 I don't know if you remember, when we did PET,
11 which also, of course, comes from NMTCB, we accepted
12 that registry, there also was not a practice
13 standard. This was, back in 2012, rolling over into
14 2013. There was the General Nuclear Medicine
15 Society, Society of Nuclear Medicine had, which is
16 the professional association that produces these
17 things for the registry, NMTCB. They had kind of
18 incorporated into the base document for all nuclear
19 medicine technologists. That wouldn't work because
20 in order for us to pass, to go through the rule
21 making to create a category in Florida, we have to
22 have a practice standard that's specific to this.

23 When we did PET, Society Nuclear Medicine, I
24 think we were actually the reason that they went
25 back and created a PET specific practice standard,

1 do you remember that? So when it came time to do
2 this for CT, the same kind of problem happened.
3 which is that, oh, the base document, the nuclear
4 medicine practice standards -- which are in the
5 corner over there if you want to see a copy or up on
6 the web later on -- because they recalibrated the
7 profession, basically, to incorporate CT, much more
8 so than just about any other profession, they, they
9 didn't have a specific document for that.

10 So at this point in time, in 2015, Cybil
11 basically said, well, ASRT, which is the practice
12 standards that we've had in rule at that time for
13 the folks who we were issuing CT licenses for,
14 because it came from ARRT and ASRT had the practice
15 standard for it, Cybil said they're in negotiations,
16 they are in discussions with ASRT and rather than
17 come up with one for ourselves, we're just going to
18 pursue this and see if ASRT will incorporate our
19 registry into their practice standard -- which
20 they've done many years in the past. If you look at
21 the ASRT practice standard for nuclear medicine, it
22 covers both registries. So this is something that's
23 been done in the past.

24 Okay. That's a long way. So fast forward to
25 now. And the Society of Nuclear Medicine has

1 written letters to us; written letters to Chantel,
2 and NMTCB has written letters, I didn't know until
3 Chantel came in here and said, oh, look, there's
4 another letter from NMTCB.

5 So they have convinced ASRT as of June 2017,
6 in their new -- in ASRT's new practice standards,
7 which look like this -- I do have a couple copies of
8 this.

9 LYNN ANDRESEN: I have two copies if anybody
10 wants to look at them.

11 JAMES FUTCH: There's one there. I'll
12 circulate one this way. There's one on this side of
13 the room if anybody wants to look at.

14 In their practice standards for June 2017,
15 they do now include NMTCB-CT. And let me go back
16 here for just a second and I'll just throw it up on
17 the board here for a second -- on the screen here
18 for a second. So this is the CT practice standard.

19 CHANTEL CORBETT: Page five.

20 JAMES FUTCH: This is the one date some place,
21 effective June 25th, 2017. I think I have it
22 highlighted in here. It will hit me in the face.
23 There it is. That's the relevant section, right?

24 CHANTEL CORBETT: Mm-hmm.

25 JAMES FUTCH: Okay. So education



1 certification, you all can read it for yourself.
2 Eligibility to take the post primary exam computed
3 requires the appropriate primary certification.
4 You've got to be nuclear med or radiography or
5 something. Documentation, structure, education,
6 clinical experience, all that stuff that I talked
7 about.

8 Those passing ARRT use the credential this.
9 Those passing NMTCB. So this is the first time this
10 is now reflective of the fact that, yes, there is an
11 NMTCB pathway into use of these practice standards.

12 CHANTEL CORBETT: The paragraph right above
13 your highlight is the one that says by obtaining
14 appropriate primary certification from either of the
15 two. So that gives you the primary has to come from
16 one of those before they can take this.

17 JAMES FUTCH: This right here. Now, here's the
18 interesting thing. There's almost -- Lynn went
19 through and compared this practice standard to the
20 one we currently have adopted in our regulation for
21 use by Florida CT techs. I think this is like the
22 only two paragraphs.

23 LYNN ANDRESEN: That was 2011.

24 JAMES FUTCH: Yeah.

25 LYNN ANDRESEN: So --

1 JAMES FUTCH: There may have been -- I doubt
2 this one was in between.

3 LYNN ANDRESEN: I'm not sure.

4 JAMES FUTCH: They don't do it that often. So
5 there's very little difference in the actual
6 standard in what you can do and, you know, the
7 general requirements, the specific duty; things of
8 this nature. It was basically this -- made it a
9 little more generic in some places and specifically
10 referenced NMTCB-CT. That was a long way to go,
11 but --

12 RANDY SCHENKMAN, CHAIRPERSON: Are the programs
13 similar or are they different?

14 JAMES FUTCH: well, you mean --

15 CHANTEL CORBETT: what do you mean by program?

16 RANDY SCHENKMAN, CHAIRPERSON: I mean the -- to
17 become certified, is it more similar now or is it
18 still very different?

19 CHANTEL CORBETT: It's the same thing. I mean,
20 than it was. It is 500 clinical hours in a CT
21 environment.

22 RANDY SCHENKMAN, CHAIRPERSON: But not
23 specified as to --

24 CHANTEL CORBETT: Not specific exams. The
25 problem, for the most part, with the exam's

1 specification, is that if you're employed at an
2 oncology center, let's say, you may do five, at the
3 most, of the 125 options. And that means you would
4 have to go outside of your current employer to be
5 able to get those other tests. And there's really
6 no point, honestly. And the whole point of this,
7 really, is not nuclear medicine to go take over a CT
8 job in a hospital. This is mostly for the oncology
9 centers who have a PET CT and they are putting
10 diagnostic CTs in between their PETS, right now they
11 are having to employ two different technologists,
12 for the most part. So it's going to prevent that
13 requirement.

14 I'm not saying that everyone is going to
15 switch to the dual, but we've already got hospitals
16 in Florida who have said, as soon as this goes
17 across, you know, we'll -- we have no problem. We
18 can use that nuclear med tech that has a CT license
19 as a back up for CT in our CT department. But at
20 that point, they're going to drop down to the CT pay
21 grade. They're not going to get their nuclear med
22 pay to go into CT.

23 And so that's the other thing that I think a
24 lot of people really want to push from a nuclear med
25 perspective is, we honestly get paid better doing

1 nuclear med. So this is not something we're really
2 trying to push into the CT, you know, field to just
3 go do CT. This is really to incorporate it into
4 their jobs where they're in an oncology center and
5 they have that option.

6 KATHY DROTAR: And that was a good part of it
7 because the, the CT person couldn't do the nuclear
8 med portion of it. They need that nuclear med
9 person there, as you well know.

10 CHANTEL CORBETT: Correct.

11 KATHY DROTAR: But the other thing was that
12 nuke med people who were nuke med couldn't train in
13 CT because they weren't covered by the --

14 CHANTEL CORBETT: Schools.

15 JAMES FUTCH: The student exemption.

16 CHANTEL CORBETT: Right.

17 JAMES FUTCH: The Florida law is still written
18 basically, unless you're in that particular area,
19 you can't do those kinds of images unless you're a
20 student. Student meaning in the, in the tradition
21 of, hey, there's an accredited school, you're an
22 enrolled person attending it and you can do it.

23 Now, there are some programs that do that in
24 Florida. They kind of, I think, recognize the --
25 I'll give you some numbers. But 2100, 2200 total

1 nuclear medicine technologists in Florida, ballpark.
2 And when we started this in '98, I think there was,
3 like, 1800. And I don't know, but a fairly high --
4 you work in the field. Alberto, you were nuclear
5 med. I think a fairly high percentage of nuclear
6 medicine departments and nuclear medicine techs, I
7 mean, CT, PET CT has kind of taken over a fair
8 amount of what's going on.

9 So this is a big deal. This is why they put
10 it in the curriculum in 2011 for the core nuclear
11 medicine technologists.

12 CHANTEL CORBETT: Truthfully, from my research,
13 and I may be wrong, outside of Florida, but in
14 Florida, the majority of the nuclear med programs
15 offer more CT education in their program than x-ray
16 does.

17 KATHY DROTAR: Yeah.

18 CHANTEL CORBETT: So, you know, as of this
19 point, you can come out of an x-ray classroom and do
20 on-the-job training and get CT certified.

21 JAMES FUTCH: which brings us to --

22 CHANTEL CORBETT: -- and be done with no
23 additional anything.

24 JAMES FUTCH: Now, Tim Williams made -- went
25 back and forth, a lot of questions to Cybil in here

1 from Tim. And one of the points that he brought out
2 was, you can be certified in the primary area of
3 radiography in Florida and because that primary area
4 licenses you and covers any form of x-ray, you can
5 do CT without getting a CT certification from either
6 the State of Florida or from either one of the
7 national registries.

8 CHANTEL CORBETT: Right.

9 JAMES FUTCH: That's perfectly legal. That's
10 allowed.

11 CHANTEL CORBETT: Right.

12 JAMES FUTCH: Tim ended up, as I read the
13 minutes, Tim ended up coming down on the side of,
14 well, what they're doing is better than that. You
15 know, it's much better. I'm not saying it's bad in
16 any way, shape or form, but he ended up, I think,
17 saying --

18 CHANTEL CORBETT: More education.

19 JAMES FUTCH: There's a lot more education
20 involved in this, and you've still got to pass that
21 test.

22 And let me show you, because you had asked
23 something about --

24 CHANTEL CORBETT: The exam covers a lot more.

25 JAMES FUTCH: You had it in hard copy I think,

1 right?

2 CHANTEL CORBETT: I did. I gave you what I
3 had.

4 JAMES FUTCH: Content specifications. There it
5 is. So this is off the website last night. CT
6 content specifications. Standard 200-question exam.
7 And the person who has done this has completed the
8 500 hours and the 35 of the, of the contact.

9 You can see, we're talking about general areas
10 here, fifteen percent of the questions, patient
11 handling. Fifteen percent medications; contrast
12 agents. Nuclear medicine always gets heavily
13 involved in those areas, for obvious reasons.

14 Procedures and anatomy. Here's where it
15 starts to get out into the nitty gritty. Exams of
16 the head. You see exams of the neck, spine,
17 musculoskeletal; chest.

18 I mean, you know, a lot of detail about -- I'm
19 sorry, Alberto, did you.

20 ALBERTO TINEO: So this is going to become more
21 of an issue going forward, so it was going to start
22 January of 2018, but I think it was delayed, but CMS
23 now is going to require anybody doing CT's to be --
24 to have some kind of certification. You cannot be a
25 tech without certification in CT.

1 So they're either going to have the ARRT-CT or
2 the NMTCB-CT. So I think we're just at the end of a
3 wave that we're going to have to allow this to
4 happen as long as they have good education. Because
5 it's just, it's just a matter of time that nobody
6 can perform CT without certification in that field.

7 JAMES FUTCH: Let me show you one more thing,
8 also. And you and -- you had some thoughts, too,
9 on -- because you were here before and I think a lot
10 of folks had questions. But it seems like, in
11 talking to everybody, we've kind of adjusted to this
12 and it's --

13 ALBERTO TINEO: Yeah, I think at the end, it
14 was just -- we were just waiting for them to take
15 the -- to convince the ASRT to allow them to accept
16 NMTCB as part of the scope of practice. So as soon
17 as, I think where we ended was, as soon as that
18 happened, the council at that time was okay to
19 proceed with this.

20 KATHY DROTAR: It was the timing was in
21 allowing the curriculum to go before the ASRT as the
22 delegates to get voted on and accepted and it is.

23 ALBERTO TINEO: Correct.

24 CHANTEL CORBETT: Yeah, I mean, honestly, if
25 the Florida regulations would allow, outside of the

1 student exemption, I think we would have tons more
2 already through ARRT. It's just the fact that most
3 full-time technologists, the ones that are out in
4 the field, they don't have the time or money to go
5 back, outside of their normal business hours, you
6 know, into a school program at this point.

7 I've had people travel outside the state even
8 to get those clinical hours done. So where it's
9 legal to do it. And then, you know, get their ARRT.
10 Because that -- their job really kind of depended on
11 it.

12 JAMES FUTCH: So some of the discussion went
13 back and forth. It was like we had the 125 exams
14 camp and the 500 hours camp, which is kind of
15 reflective of the way, you know, NMTCB, up until
16 December 2015, used to have, what did they call it,
17 alternative --

18 CHANTEL CORBETT: Pathways.

19 KATHY DROTAR: Yeah.

20 JAMES FUTCH: Pathway. it was for the base NMT
21 exam, they would allow, it was 4,000 hours you had
22 to have and not a certain number of exams in a
23 certain number of -- because historically, that's
24 the way they are verse the other registry. So it's
25 like there's good and bad in both.

1 The commentary before talks about, well, you
2 can go and take 125 exams and, you know, if you're
3 doing rotations through emergency or something like
4 that in a big hospital, you can do 125 in, like, two
5 weeks or three weeks.

6 CHANTEL CORBETT: You can do each exam five
7 times, so really divide that by five and that's how
8 many you have to have.

9 JAMES FUTCH: Or you could say, well, you could
10 take the 500 hours and you could do it all in, you
11 know, just this particular area that's only
12 available and the rest of it. And you can see that
13 both of those, it would kind of be nice if we had
14 like a certain minimum number of exams and certain
15 number of hours for both of these groups, but that's
16 not under our control.

17 KATHY DROTAR: I almost think they're
18 comparable in what they look at. All of the ARRT
19 examinations are competency based, where when you do
20 it, you have somebody who is registered in that
21 discipline to oversee you and make sure that you are
22 doing it and that you're competent. They sign off
23 and verify it so that you've done practice on it and
24 now you're doing it.

25 with the -- and part of that is because the,

1 in the core curriculum, in x-ray, you're learning
2 about x-ray and safety and, and, and most of us have
3 included more CT or axial pathology, et cetera, in
4 the curriculum. And what, what -- NMTCB is doing,
5 you would need this many hours and so, it comes down
6 to probably doing similar things, just the apple and
7 oranges way of looking at it. The curriculums are
8 the same.

9 CHANTEL CORBETT: Yeah, I mean, nuclear
10 medicine, we've had cross sectional anatomy in our
11 curriculum for, basically, since SPECT has been
12 invented, you know, whereas, you know, you don't get
13 that in a lot of the other programs. So it comes
14 down to more specific CT; anatomy, obviously, being
15 able to read that and the didactic requirements.

16 JAMES FUTCH: So this is the form that's
17 required as part of the application process. This
18 is the, basically, the validation of the 500 hours.
19 It's got some instructions.

20 I really kind of expect, as time goes on, most
21 people are going to get most of these done as part
22 of their base nuclear medicine program. And the
23 people who aren't doing that probably have already
24 done, a large number of them have done the ARRT
25 method. And I haven't seen the numbers. It would be

1 interesting to see --

2 CHANTEL CORBETT: The ARRT method really has
3 not been done because they're not allowed to touch
4 the go button. I mean, that's what this comes down
5 to.

6 JAMES FUTCH: I'm really not supposed to,
7 but --

8 CHANTEL CORBETT: well, I mean -- and we kind
9 of tried to, even at some point, we've asked, like,
10 can we get something in writing saying that if we do
11 everything else in the exam that we're allowed to do
12 and not touch the start button, can we count that?
13 But nobody would ever give the written yes. So,
14 really, that's the hold up on the ARRT version.

15 JAMES FUTCH: But this is the form and then you
16 can see the expectation of the 500 hours right there
17 in the middle. It talks about what kind of standard
18 you use and all that. But the expectation is that
19 the hours include at least, you know, these kind of
20 generic categories.

21 And they talk about not requiring a specific
22 number of CT's because I think the hours is more
23 important, because it takes a while to do 500 hours.

24 Anyway, that's, that's the form for that.

25 So here's where we're at as the Bureau. We

1 had quite a bit of information, minimum MNTCB
2 provided before. We read the rules and statute back
3 then. Really, the only thing that seemed to be
4 holding us back, based on the sense of the council
5 was, waiting for ASRT to put folks from NMTCB-CT
6 pathway into their document. That's no small thing.
7 This is the American Society of Radiologic
8 Technologists. This is largely thought of being
9 associated with the other registry. So they
10 could've said, pound sand, but they didn't.

11 So at this point, I think we have what we need
12 to proceed and make the regulation changes to start
13 accepting someone from NMTCB-CT registry into the
14 Florida -- and we have to do this anyway. We need
15 to update the ASRT practice standards regardless
16 because these are the current ones. The ones we
17 have are old ones from few years back.

18 Once we do that, we've, just for the other
19 side of the coin for the existing CT techs, we've
20 already got NMTCB in the practice standards. It
21 would be kind of silly not to allow them to be
22 certified at that point.

23 So we have a couple different areas that we
24 have to go modify and put some language together and
25 start that whole process, which as I've mentioned to

1 a few people, is not quick anymore. I mean, you're
2 talking minimum ninety days, and we had one that
3 took a year, right?

4 BRENDA ANDREWS: Yes, we did.

5 JAMES FUTCH: That was really without any --

6 BRENDA ANDREWS: Actually was.

7 JAMES FUTCH: -- objecting to a lot of stuff at
8 all.

9 So that's the issue, I guess, is does the
10 council agree. Should we do this? Should we start
11 the ball to accepting CT from NMTCB into the Florida
12 certification so they can become certified as CT
13 techs in Florida.

14 ALBERTO TINEO: I make that motion.

15 KATHY DROTAR: I second.

16 RANDY SCHENKMAN, CHAIRPERSON: Are we ready for
17 a vote? All in favor? Say aye.

18 ALL: Aye.

19 RANDY SCHENKMAN, CHAIRPERSON: Opposed?

20 (No Response)

21 RANDY SCHENKMAN, CHAIRPERSON: Okay. That
22 passes.

23 JAMES FUTCH: They should all be like that.

24 RANDY SCHENKMAN, CHAIRPERSON: Yeah. Actually,



25 your next paragraph says medical imaging and

1 radiation therapy professionals performing multiple
2 modality hybrid imaging should be registered by
3 certification agencies recognized by the ASRT.

4 JAMES FUTCH: That's good.

5 RANDY SCHENKMAN, CHAIRPERSON: So we can use
6 that as a part of --

7 JAMES FUTCH: I see what you mean.

8 RANDY SCHENKMAN, CHAIRPERSON: -- your rule.

9 JAMES FUTCH: So with your permission, moving
10 on to another part of the --

11 RANDY SCHENKMAN, CHAIRPERSON: Absolutely.

12 JAMES FUTCH: If you were to go and look at the
13 regs. that we've adopted in the past, there are
14 practice standards for CT; there's practice
15 standards for PET; there's practice standards for
16 mammography. All of those are the ASRT practice
17 standards.

18 we have three areas of primary certification
19 for which no actual practice standard is adopted in
20 Florida regulation or law. You have, instead, what
21 we've been riding on for many years is in the
22 statute, it talks about the practice of radiologic
23 technology. And that term has been defined -- and
24 let me find it for a second -- in a fairly simple
25 way.

1 The practice of radiologic technology means
2 the performance of activities requiring special
3 knowledge and skills, including positioning and
4 technique, safe operation of radiation equipment and
5 radiation protection.

6 It's kind of minimalistic. For example, it
7 doesn't even mention contrast or any of the other
8 things. To show you by comparison, standards,
9 here's radiography at the national level. This
10 document -- whoops. It's thirty-two pages long.
11 You know, practice standards are not super specific,
12 but they are not that minimalistic. So this is
13 radiography.

14 LYNN ANDRESEN: James, I have copies of
15 radiography, nuclear medicine, and radiation therapy
16 if someone would like to look at them.

17 JAMES FUTCH: Okay. Thank you.

18 So we were thinking, hey, we're adopting these
19 practice standards for all of the specialty areas
20 that have low numbers, relatively low numbers of
21 technologists actually certified. We have 19,000
22 general radiographers, give or take; 2200 nuclear
23 medicine technologists and just under 2000 radiation
24 therapy technologists and all they have for a
25 practice standards is what I just read to you, which

1 is not even two sentences long as displayed in this
2 particular regulatory document.

3 on the other hand, here's a nice national
4 association that has many, and the one for nuclear
5 medicine is even written to cover both of the major
6 nuclear medicine registries.

7 would it not be better, with the Council's
8 agreement, to go and adopt the document, for
9 example, this radiography one, for our general
10 radiographers that says, it's not overly
11 restrictive, but it does have more meat on the
12 bones. And a lot of these areas we get asked about
13 over time. We've had to come back to the council in
14 this particular case of nuclear medicine a number of
15 years ago, and ask because the issue of medication
16 kind of comes up every once in a while if we can do
17 this, right? And we brought reams of documents to
18 the council. We brought the curriculum standards
19 for nuclear medicine. We brought the content
20 specifications for the -- especially the NMTs for
21 the exam, it's a little more specific, and
22 explained, hey, these are what nuclear medicine
23 techs are being educated to do. This is the kind of
24 stuff they're being tested on. And throughout the
25 whole thing, just to use the example, medication

1 administration, NMTCB'S were so specific, it had
2 lists of pharmacological agents that they are tested
3 on.

4 So it seemed, at least from our perspective,
5 that this might be something that would be a good
6 idea. But we wanted to hear from you. And when I
7 say good idea, I mean to actually go and let's adopt
8 a practice standard for one of the other areas, from
9 the national registries, and use that.

10 ALBERTO TINEO: I think would be a great idea,
11 because this comes up a lot in hospitals, of techs
12 that are allowed to do everything according to the
13 scope of practice, but the scope of practice is
14 really this one. Nobody's in their license. So I
15 think it would be concurrent with what the practice
16 really is.

17 KATHY DROTAR: well, there's also one for
18 limited licensure.

19 JAMES FUTCH: Yeah.

20 KATHY DROTAR: So if there's any certification
21 exam or discipline, there's a practice standard for
22 each of them. But one of the things that happens
23 is, on an annual basis, all of these practice
24 standards and scope are all reviewed by committees.
25 And then any modifications -- so that they are

1 maintaining the current practice standard. And any
2 changes that are -- any changes are voted on by the
3 house of delegates so that it's representative of
4 practice throughout the United States. Not just any
5 one area.

6 RANDY SCHENKMAN, CHAIRPERSON: So if that's the
7 case, then would it be possible to put it in writing
8 that we keep the most updated of the practice
9 standards for each of the groups?

10 JAMES FUTCH: You can at least start with a
11 motion that says you think these are good documents
12 to adopt by the Bureau.

13 I just wanted to show you before anybody
14 starts making motions. This is the way the practice
15 standards are organized. Here's a general
16 description of the scope in the beginning, which is
17 kind of like common sense, right?

18 Evaluating images, performing quality
19 assurance, et cetera, et cetera. Also includes
20 these other things. And then you go into different
21 areas, like, for example, the first area is
22 assessment; clinical performance standards.

23 There would be a rationale. There would be
24 general criteria. Sometimes the general criteria is
25 fairly specific. Sometimes it's actually, as the

1 name implies, fairly general.

2 And then afterwards, there would be specific
3 criteria. So this is kind of like if you really
4 want to go and see what it is your profession does,
5 you start looking through all of these specific
6 criteria and general criteria, each of the different
7 subject areas.

8 So here's analysis determination, standard
9 number two, the general criteria, selects the most
10 appropriate action plan, determines course of
11 action, et cetera.

12 Some of these make my eyes glaze over.

13 MARK SEDDON: Are there any standards which
14 conflict with what are in the current regulations?

15 JAMES FUTCH: We have to go through, like we
16 did, if you remember, the radiologic assistant way
17 back in '08, '06, something like that, we'd have to
18 read it and make sure there isn't anything, as Mark
19 implies, that would directly contradict, like, the
20 law for the --

21 MARK SEDDON: Fluoroscopy.

22 JAMES FUTCH: -- the law for radiologic
23 assistant excluded nuclear medicine and therapy.
24 And the radiologist assistant's practice standard,
25 at least back then, had a few areas that spoke to

1 that issue. And so when we adopted it in the
2 regulation, we had to say, you know, we adopt this,
3 and this is the scope, with the exception of number
4 whatever, which contradicted the statute. So we'd
5 have to go through and do that.

6 KATHY DROTAR: We're all -- it's within the
7 scope of practice for a radiologic technologist to
8 perform.

9 MARK SEDDON: And monitor.

10 KATHY DROTAR: But not in order to -- but it
11 can't be used in order to position a patient.

12 JAMES FUTCH: Yeah.

13 KATHY DROTAR: So that there's that
14 delineation. You can do, you can do a procedure,
15 but you can't use it just to go in and center L4,
16 L5.

17 JAMES FUTCH: There's actually a different
18 regulation in Florida Administrative Code that
19 speaks to that issue you're talking about.

20 KATHY DROTAR: Yeah.

21 JAMES FUTCH: Mark is probably thinking about
22 that, too. Obviously, things have to be adapted,
23 too, to what would be -- if there's statutory
24 authority for it, we can change the regulation if
25 it's conflicting with something that makes sense at

1 the national level.

2 Anybody want to see therapy or nuclear
3 medicine? It's more of the same.

4 CHANTEL CORBETT: No.

5 JAMES FUTCH: Different words.

6 KATHY DROTAR: I've seen them.

7 JAMES FUTCH: A few different words. Same
8 general idea.

9 CHANTEL CORBETT: I don't see specifically is
10 contrast in the nuclear med practice. I think the
11 SNM actually specifies --

12 JAMES FUTCH: Really?

13 CHANTEL CORBETT: It does say medication, so
14 I'm sure it's under the definition.

15 JAMES FUTCH: At the end of the practice
16 standards, I didn't pull up all the little
17 associated documents, but there's, like, the last
18 page or two, there's a whole bunch of specific
19 documents about different, I call it -- I like to
20 think of it as problem areas. You know, there are
21 some areas we've had some difficulty in the past, so
22 we need to say some specific stuff. It could be in
23 one of those because there's a lot of medication and
24 related stuff on there.

25 KATHY DROTAR: Chantel, that also might be

1 in -- under the practice standards. There's another
2 document that has some of those other things in it.

3 CHANTEL CORBETT: Okay.

4 JAMES FUTCH: I know it's more specific than
5 the means of performance of activity requiring
6 special knowledge and skills including position
7 techniques, safe operation radiation, radiation
8 protection. It's a lot more specific than that, but
9 still not, not being completely constricting. It
10 still had some fairly, you know, general areas to
11 it.

12 CHANTEL CORBETT: That would be my only
13 concern, just to make sure that that's included. So
14 that if a hospital, for instance, is going to say,
15 you've got to go by this, and that excludes
16 contrast, then that would be an issue.

17 JAMES FUTCH: And we'd definitely take that
18 into account.

19 RANDY SCHENKMAN, CHAIRPERSON: Okay. So I'll
20 move to accept these practice standards, depending
21 on the laws of the State of Florida, and updating
22 them as needed as if the practice standards are
23 updated by the national registries. Does that make
24 sense?

25 MATTHEW WALSER: I second.

1 RANDY SCHENKMAN, CHAIRPERSON: Anybody want to
2 comment on it? Change it in any way? Okay. Can we
3 take a vote? All in favor, say aye.

4 ALL: Aye.

5 RANDY SCHENKMAN, CHAIRPERSON: Opposed?

6 (No Response)

7 RANDY SCHENKMAN, CHAIRPERSON: None. Okay. So
8 we passed it unanimously.

9 JAMES FUTCH: All right. Thank you for your
10 guidance.

11 LYNN ANDRESEN: Two for two.

12 JAMES FUTCH: Do you want to do your stuff?

13 CYNTHIA BECKER: Sure.

14 JAMES FUTCH: Lynn, is there anything else that
15 we --

16 LYNN ANDRESEN: No, those were the two main
17 items.

18 JAMES FUTCH: Okay. So -- well, that's it for
19 me.

20 RANDY SCHENKMAN, CHAIRPERSON: Okay. So now we
21 have the Radioactive Materials Update.

22 CYNTHIA BECKER: Yes. And the update, for one
23 thing, talking a little bit about this earlier at
24 lunch, but one of the things that we do during an
25 impending storm is we call the IC licensees or try

1 to contact them through e-mail. The ICs are
2 increased controls licensees. We have about 60 of
3 them that have the higher risk sources.

4 And we put out a message to them before the
5 storm saying, basically, secure your sources; let us
6 know if you need any help. Make sure we have the
7 proper contact for you. And then, please let us
8 know after the storm passes if your sources are
9 still secure.

10 So we did that message pre-storm and we also
11 did that message post-storm. And in past years, we
12 knew more of an area that the storm was headed to.
13 This year, of course, we just sent that out to all
14 of them.

15 JAMES FUTCH: Pensacola, too?

16 CYNTHIA BECKER: Yeah. Yeah.

17 RANDY SCHENKMAN, CHAIRPERSON: Be on the safe
18 side.

19 CYNTHIA BECKER: And we did really well here in
20 the State of Florida. Texas, I know they did have
21 some issues with flooding and with problems with
22 sources.

23 The other thing that we do that you may not be
24 aware of is that the nuclear power plants, they are
25 required by NRC to start powering down when tropical

1 force winds are expected to be within 48 hours of
2 hitting their plant. And so St. Lucie and Turkey
3 Point both started shutting down, which they did. I
4 think they power about twenty percent of the
5 electricity in the southeast area of the state.

6 So shutting down means, of course, now, you
7 know, having more issues with the electricity in the
8 area. So they did power down.

9 One of the requirements, then, that NRC has is
10 before they can start back up, they have to have us,
11 as our contracting person with them -- our contract
12 stipulates that for the power plants, we will go in
13 and we will survey their monitoring and surveillance
14 equipment to make sure that there was no damage
15 during the storm so that when they start back up,
16 their surveillance and monitoring equipment are
17 working properly.

18 And our staff do that. The staff that work
19 out of our Orlando environmental radiation for John
20 Williamson, that's what they do right after the
21 storm passes and it's safe enough for them to travel
22 to the plant. So that those, those surveillance and
23 monitoring equipment were inspected as well and
24 found to be operating. So the power plants came
25 back up fairly quickly.

1 So that's kind of the storm-related
2 activities.

3 The other update is that I think Chantel
4 brought this up at one point. Was it the last
5 meeting or was it the meeting -- because --

6 JAMES FUTCH: It was in between.

7 CHANTEL CORBETT: I wasn't here last time.

8 CYNTHIA BECKER: Yeah, it was the one I wasn't
9 here and you were here.

10 JAMES FUTCH: I think it came in since the last
11 meeting if I remember right. You asked about this.
12 Decay and storage.

13 CHANTEL CORBETT: Yes.

14 CYNTHIA BECKER: Decay and storage issue. NRC,
15 as you know, and I think James mentioned this also,
16 is that we're an agreement state. There's 38, 39
17 agreement states I think now, which means that we
18 signed an agreement that we would regulate all
19 radioactive materials within the state with the
20 exception of federal facilities and nuclear power
21 plants. So we do our regulations. But, of course,
22 we have to be compatible and adequate health and
23 safety regulations with them.

24 A lot of things are compatible, ABC, which
25 basically means they're either going to be verbatim

1 what the NRC requires or we have a little bit of lax
2 in certain areas, as long as we're still health and
3 safety related.

4 We can be more restrictive in a lot of cases,
5 and the decay and storage may be one of those
6 issues. It came up in, interestingly, you brought
7 it up, but then also Mike Stevens is kind of our
8 rule guru. You know, he's been with us since 1985.
9 He went to the Office of Agreement state meeting,
10 which is sort of a subset of the radiation program,
11 program director/NRC, it's, as it says, Office of
12 Agreement States. What they do it's a formation of
13 the Agreement States, 38, 39 of them, and the staff
14 from them get together and discuss NRC rules,
15 compatibility requirements, and discussions come up.
16 And that came up in a meeting which was just in
17 August.

18 Were you there?

19 CHANTEL CORBETT: No, but I figured it might
20 come up.

21 CYNTHIA BECKER: Okay. It came up. And the
22 issue, I guess, first to explain the issue, is that
23 NRC does not require for medical sealed sources to
24 decay and storage. They allow them to be disposed
25 of if surveys -- proper, adequate surveys, show that

1 the sources are now at background radiation, then
2 they can call a company and dispose of them.

3 CHANTEL CORBETT: Prior to the ten half lives.

4 CYNTHIA BECKER: Right. Prior to the ten half
5 lives. In our rules, we still say you have to wait
6 ten half lives in order to -- you're decaying and
7 storage is what we're doing. You're holding that
8 for ten half lives until you can safely dispose.

9 So when that came up, they asked some of the
10 states that had gone with the NRC and changed their
11 rules to allow that now, to allow disposal.

12 what they were finding and Mike had said that
13 they were finding that there were a few more
14 compliance issues. They were finding violations
15 from licensees who were not doing proper surveys.
16 They are not using -- taking away the shielding and
17 doing a survey, which is important. Some of the
18 licensees were keeping shielding in place and doing
19 the survey; and therefore, thinking they can dispose
20 now. And then some of it was ending up actually in
21 the waste stream.

22 Now, that's what he said a few states had
23 said.

24 JAMES FUTCH: The waste stream, by the way, is
25 monitoring itself now.

1 CHANTEL CORBETT: Not like water.

2 CYNTHIA BECKER: Yeah, not like water. Waste
3 stream, in like the land fills.

4 CHANTEL CORBETT: My only response to that
5 would be if they're going to do that for that
6 method, I don't see them doing anything different if
7 they waited ten half lives. If they think that
8 they're going to be able to do the monitoring with
9 the shielding still present, then, if that's their
10 train of thought, I don't see their train of thought
11 changing after ten half lives. They still would go
12 that route. Maybe I'm wrong.

13 ADAM WEAVER: That's a key, too. It's also a
14 minimum of ten half lives. Some things you have to
15 keep longer.

16 CHANTEL CORBETT: Correct. You still have to
17 monitor -- some things are not.

18 ADAM WEAVER: Right.

19 CYNTHIA BECKER: So it's the minimum, right.

20 And one of the things, too, that came up is
21 that, you know, are we having any questions from
22 licensees. We haven't had any. I don't know --

23 JAMES FUTCH: Chantel has been answering all of
24 them.

25 CYNTHIA BECKER: Okay. See.

1 CHANTEL CORBETT: That's actually why I called,
2 because I had quite a few of my clients asking.

3 CYNTHIA BECKER: Really?

4 CHANTEL CORBETT: Yeah.

5 CYNTHIA BECKER: So we haven't, beside you
6 bringing it up, we haven't heard that part of it
7 yet. But the other thing that some of the states
8 brought up that their licensees brought up when they
9 changed it is that it was costing them more because
10 they were having to contact disposal companies, like
11 it was costing more to dispose than just for them to
12 decay and storage and then discard.

13 CHANTEL CORBETT: That doesn't make sense,
14 because the only thing we have to pay to dispose of
15 now, is things that we cannot decay in storage.
16 Like --

17 CYNTHIA BECKER: Okay.

18 CHANTEL CORBETT: There would be no reason to
19 pay anybody.

20 ADAM WEAVER: Unless you're paying them to take
21 it off your site for decay and storage.

22 CYNTHIA BECKER: Right.

23 CHANTEL CORBETT: Right. That doesn't make
24 sense.

25 ADAM WEAVER: Or returning the source to the

1 vendor.

2 CYNTHIA BECKER: Right, then you have to pay
3 for that.

4 CHANTEL CORBETT: We've had actual state
5 inspectors tell clients in other states that they've
6 come from previously, that this is why all this
7 started, that once it was dead, you could just pull
8 the labels off and throw it away. And so, we
9 actually had somebody do that and luckily, I found
10 out within 12 hours and it was still in Sharpes
11 container. So that's why I started investigating
12 and I'm like, I've never heard of such a thing.
13 Like, that sounds absurd.

14 But then there was the NRC rule that actually
15 said, like you could do it if it was background and
16 you could throw it away. So I guess it depends on
17 how it's interpreted as throw it away, you know, if
18 it's dead.

19 CYNTHIA BECKER: Right.

20 CHANTEL CORBETT: So if it's a sealed source,
21 if you have a cookie sheet, you know, sheet source
22 for a camera and it's dead, you know, is throwing it
23 away taking the labels off and throwing it into a
24 normal trash can. Because there's -- there is no
25 labeling at that point and it's dead. Or are you

1 still going to require them to pay to ship it out.

2 In that case, to me it doesn't change anything
3 because right now, I've got people with twenty
4 sources that are dead sitting under their cabinet
5 because they don't want to pay to ship them out and
6 go back to the manufacturer.

7 CYNTHIA BECKER: So that wouldn't change.

8 CHANTEL CORBETT: So if they would throw them
9 away in the normal trash, that would be free and we
10 would have that many fewer sources in inventory.
11 But right now, they're not shipping them back
12 because with the cesium vial, you know, it's \$600
13 plus shipping. With a germanium source, for a PET
14 source, it never goes under \$600, no matter how dead
15 it is, plus shipping. You know, a Cobalt sheet
16 source goes down to \$200 plus shipping. So -- and
17 they only will do a one-for-one exchange.

18 So when a client buys a new source, typically,
19 it's including to shipped one dead; one back. That
20 only is good for six months.

21 They do have a, depending on the person and
22 how nice you are to them, they may give you a couple
23 more months on that. But a lot of people will sit
24 on that for whatever reason, they don't send them
25 back and so they start accumulating all these dead

1 sources and so they have these cabinets full of dead
2 sources that, you know, we're still having to
3 inventory to make sure that they are still there.

4 CYNTHIA BECKER: And that came up because, that
5 came up as far as now we have to do inventory, we're
6 storing those sources.

7 CHANTEL CORBETT: Right.

8 CYNTHIA BECKER: So it was almost like this, do
9 you change it, do you not change it, you know.

10 CHANTEL CORBETT: Right.

11 CYNTHIA BECKER: It takes, as we talked about
12 before, a long, long time to change something.

13 CHANTEL CORBETT: Right.

14 CYNTHIA BECKER: But the thought was that if
15 they started hearing from people, and you said you
16 are hearing from licensees to change it, but then
17 the only thing is we'd have to be really careful
18 about the other part of that is to make sure that
19 they're not doing that and just removing the labels
20 and going, oh, heck with it.

21 CHANTEL CORBETT: But why not? Why would we
22 want to not do that?

23 CYNTHIA BECKER: Right. If it's truly, if it's
24 truly background and there's no radiation and you do
25 the surveys properly, yeah.

1 CHANTEL CORBETT: Yeah. I mean, I guess that's
2 the caveat in the whole thing is how you prevent
3 that from being an issue. But it's the same kind of
4 thing with outpatient iodine therapies. You know,
5 you have to at some point you're going to trust your
6 licensee and you're going to trust whoever you're
7 giving a signed consent form, they're actually going
8 to do what they say they're going to do?

9 MARK SEDDON: Isn't there a half-life
10 requirement?

11 CHANTEL CORBETT: For decay and storage, that's
12 currently 120 days. That prevents you from doing
13 it.

14 ADAM WEAVER: One hundred twenty days.

15 CYNTHIA BECKER: Anything that's -- yeah, one
16 hundred twenty days.

17 MARK SEDDON: For Cobalt, you can't do that.
18 that's why you store Cobalt.

19 ADAM WEAVER: Some things are too long.

20 CYNTHIA BECKER: Yeah, there are some
21 things you can't.

22 CHANTEL CORBETT: The Germanium rod sources.

23 ADAM WEAVER: And also, those have lead in
24 them, too.

25 CHANTEL CORBETT: It depends on the source, you

1 know what I mean? We've got the flexible sheet that
2 are completely different than the glass, plexiglass.

3 ADAM WEAVER: Yeah. Depending on the
4 detectors.

5 CHANTEL CORBETT: Yeah, there's pros and cons,
6 obviously. I think most of this comes from
7 everybody -- social media these days. Like
8 everybody has a alumni Facebook groups and, you
9 know, things like that where they've got texts that
10 they went to school with that are working in other
11 states and they will say, hey, have you guys changed
12 this yet, whatever. And they go, oh, no. You can
13 do that? Oh, wait, wait.

14 So then, of course, then that hits me because
15 everybody has me as their contact. So I get people
16 who are not my clients, you know, because I'm also
17 the Society of Nuclear Medicine advocacy contact for
18 the State of Florida. And I'm also the NTC contact
19 for the State of Florida and I'm also here.
20 Basically, my name and number are the primary go to,
21 I guess.

22 CYNTHIA BECKER: And you're hearing that.
23 Well, that's exactly what came up at the OAS meeting
24 and they didn't resolve anything except for saying
25 that if different states, as soon as they heard from

1 enough people saying this is an issue, this is an
2 issue, then they, then they made changes. And then
3 when they did, they saw some things, but it's not
4 going to be, you know, like that every time.

5 CHANTEL CORBETT: Yeah. The other thought I
6 had was, you know, and it would probably prevent
7 that issue, is you could have multiple locations --
8 I don't know who, you know, if it would be like an
9 inspector hub kind of thing, where the client says,
10 okay, I've got these five sources. They're
11 completely dead. They meet the criteria. And I
12 have to bring them to you or have you come to me and
13 verify before we can dispose of them. You know,
14 like during your state inspection, you can get, you
15 know, that would maybe work, you know, during their
16 normal state inspection.

17 MARK SEDDON: Didn't we do the amnesty day with
18 Debbie Gillie a number --

19 CYNTHIA BECKER: The scatter program?

20 MARK SEDDON: Yeah, scatter program.

21 CHANTEL CORBETT: Similar to that. Even if you
22 did it --

23 ADAM WEAVER: Those are still radioactive.

24 CHANTEL CORBETT: where they did on their
25 normal state inspection cycle, that's not going to

1 prevent -- I mean, that's not going to have extra,
2 per se, trips for you guys. But I mean, as they go
3 on site to the client, if the client says, I've got
4 these five, can you please, you know, sign off
5 saying that they really are dead and I can get rid
6 of them. I mean, that might be a way to do it. So
7 that you don't have that problem with them just, you
8 know, chucking them and you find them in a landfill.
9 I mean, if they don't have labels, you're not going
10 to be able to track back to the clients.

11 CYNTHIA BECKER: You're not going to track it
12 back.

13 CHANTEL CORBETT: Maybe that's the best way,
14 just have them sign off on it during the inspection.

15 ADAM WEAVER: Some of these labels are hard to
16 remove, too. They are permanent.

17 CHANTEL CORBETT: Some of them have the thermal
18 labels on the cesiums and that stuff and after a
19 couple years, they disappear. Like, there is no
20 labeling on those vials anymore. So if you don't
21 write, like we've got masking tape and we've got all
22 kinds of other things that we've handwritten them
23 on.

24 Honestly, at that point, it's, you know, your
25 word against whoever wrote it down like, I guess

1 that's really the source that matches. So -- it's
2 an interesting game.

3 CYNTHIA BECKER: Okay. Well, so, the thought
4 I'm supposed to bring from the materials licensing
5 program is if you're collecting -- because they are
6 calling you. If you're collecting those comments,
7 if you could express those up to Charlie --

8 CHANTEL CORBETT: Okay.

9 CYNTHIA BECKER: -- Hamilton, then we'll need
10 to start looking at those and figure out if that's
11 something we need to pursue or put in place
12 something like you're saying where we change our
13 inspection approach. Something that we could do to
14 keep from having issues if it's changed.

15 CHANTEL CORBETT: Right. We've had inspectors
16 mention to clients, you know, you guys really have a
17 lot of, you know, old sources here. You really
18 should get rid of them. And it's an ALARA issue.
19 It's not an ALARA issue because they are dead. It's
20 not that part, but it is a lot of sources.

21 And hurricanes, I mean, if you have twenty
22 dead sources but a hurricane comes through and
23 floods your department and they are all gone now,
24 you have to go track them down because they were on
25 your inventory, but they've been dead for years.

1 You know, that's an issue, too.

2 LISA GAVATHAS: Some of them are pages and
3 pages long. What are these things? You start
4 digging them out from under the cabinets.

5 CHANTEL CORBETT: Pulling them out of the
6 cabinet.

7 LISA GAVATHAS: We have some up here and we
8 have some down here.

9 CYNTHIA BECKER: Does it end up costing?

10 CHANTEL CORBETT: I think that might be the
11 most streamlined way to do it, during an inspection
12 and have them sign off, because it is already in
13 their, their, you know, schedule cycle. And they're
14 already checking inventory while they are there
15 anyway.

16 CYNTHIA BECKER: Right. Okay. That's a good
17 idea. Thank you.

18 CHANTEL CORBETT: Yeah. No problem.

19 CYNTHIA BECKER: All right.

20 RANDY SCHENKMAN, CHAIRPERSON: Anymore comments
21 for this? Questions? Okay.

22 Next we go on to Brenda.

23 BRENDA ANDREWS: Okay. We have currently, two
24 vacancies on the council. I know some of you
25 remember Mary Bridget-Hart, who was in the Board

1 Certified Nuclear Medicine Physician position. And
2 she submitted her resignation in February of this
3 year due to her overload. She could not -- she
4 could no longer continue on the council, so that
5 position is still open.

6 And a little recently, Dr. Cognetta, his
7 position expired in May. So he was unable to be
8 here today, but he would've also not been a member
9 at this point.

10 So I have sent an e-mail out to Dr. Cognetta
11 and I'm waiting to hear back to see if he's
12 interested in reapplying for another three-year term
13 and I'm waiting to hear back from him. I'll
14 probably give his office a call to see.

15 Also, shortly after Dr. Hart resigned, we did
16 submit a letter to the society, but in the meantime
17 of everything else going on, they have not
18 responded. So we're definitely going to have to go
19 back and do more due diligence in getting these
20 positions filled. But in the meantime, if anyone on
21 the council knows anyone that may be interested in
22 the two vacancies.

23 I also put in your package a list of the
24 current members and it shows those two vacancies.
25 So if you know anyone that --

1 CHANTEL CORBETT: I'll contact the society.

2 BRENDA ANDREWS: -- would qualify.

3 CHANTEL CORBETT: See if I can get them to give
4 us some --

5 BRENDA ANDREWS: Okay. That would be great.

6 CHANTEL CORBETT: They are having their annual
7 southeast chapter meeting the 6th through the 8th of
8 October they're actually meeting. That would be a
9 good time. I'll reach out to them.

10 BRENDA ANDREWS: Great. Of course, Dr.
11 Cогnetta was in the lay position.

12 So we're looking to get those filled because
13 the Department is always concerned about any
14 vacancies we have on any of the councils or boards.
15 So I've really got to step it up and get these
16 filled pretty soon. Hopefully by the time we have
17 the next meeting we'll have those filled.

18 ADAM WEAVER: What's the requirements for the
19 open position?

20 BRENDA ANDREWS: James, you can probably speak
21 more to that than I can.

22 ADAM WEAVER: Is that the one you were trying
23 to look to fill with the vet?

24 BRENDA ANDREWS: One of the lay positions.

25 JAMES FUTCH: No, Dr. Cогnetta's position we

1 kind of call it the lay position. It's just -- it
2 can't be one that is a member of any of the
3 certified radiation positions or closely related
4 positions. The attorneys -- Dr. Cognetta, actually,
5 is a dermatologist and he performs radiation
6 therapy, superficial. We actually had to run that
7 one by the general counsel's office last time and
8 they said that's not close enough to worry about.

9 So if that's still what they say this time,
10 you can actually be a cardiologist using fluoro or a
11 vet using x-ray and that would be fine, judging by
12 the previous guidance. Really, anybody. It's a
13 very wide-open spot. I think -- who's the other
14 one?

15 BRENDA ANDREWS: I'm sorry?

16 JAMES FUTCH: Who's the other one?

17 BRENDA ANDREWS: Matt Walser.

18 JAMES FUTCH: So give us ideas.

19 ALBERTO TINEO: I have a question. I know the
20 last time I was up for renewal, which is going to be
21 next year, there was a lot of push to change members
22 or to -- I don't know if that was from the
23 Department or if that was from, what was the impetus
24 for that?

25 BRENDA ANDREWS: That was more so from the

1 Department at that time.

2 ALBERTO TINEO: At that time.

3 BRENDA ANDREWS: Of course, each person in that
4 position may take a -- someone else may take a
5 different stance on that. But I think the main
6 thing, the main focus during that time was to renew
7 the council so that the same members were not on
8 there for years on end, but give other people
9 opportunity --

10 ALBERTO TINEO: Okay.

11 BRENDA ANDREWS: -- to apply for it. Of
12 course, this is a unique council, so it's not like
13 you don't have an abundance of people that would
14 even qualify or be interested, everything lining up
15 for them to be a part of this council. So I think
16 they began to recognize that. And I'm not sure if
17 that's still going to be the case now. We are under
18 a new Surgeon General as well.

19 ALBERTO TINEO: I see that as a lot of --

20 JAMES FUTCH: By my count, ten next year.

21 ALBERTO TINEO: Yeah, next year.

22 JAMES FUTCH: Not counting the two we were just
23 talking about.

24 CHANTEL CORBETT: How far ahead do the
25 societies nominate for these renewal positions?

1 BRENDA ANDREWS: well, we're the one that
2 initiates that. So when there's a vacancy, we
3 submit the letters to them, letting them know that
4 we have a vacancy and that they nominated someone.
5 we give them that information before.

6 we also let them know if that person is
7 interested in renewing, we let them know that. Or
8 if the person is actually resigning from the
9 position, we let them know that as well. So they
10 can decide if they want to reappoint that person or
11 renominate that person or if they want to give us a
12 new nominee.

13 CHANTEL CORBETT: Okay.

14 BRENDA ANDREWS: But it starts with us.

15 CHANTEL CORBETT: How far ahead does it happen,
16 do you know?

17 BRENDA ANDREWS: well, in the case with Mary,
18 Mary Hart's position, we did it short -- about a
19 month after she resigned.

20 CHANTEL CORBETT: I mean for, like, the
21 renewals. That we know the date.

22 RANDY SCHENKMAN, CHAIRPERSON: we had ten. Ten
23 for next year.

24 BRENDA ANDREWS: Yes.

25 CHANTEL CORBETT: If your term is ending in

1 July, does the notice go out in July or does it go
2 out in May?

3 BRENDA ANDREWS: The notice to the person --
4 they like to give them at least thirty days once we
5 have chosen someone. So I would say about two
6 months out -- three months, three months out would
7 be a nice range for us to do a solicitation --

8 CHANTEL CORBETT: Okay.

9 BRENDA ANDREWS: -- and get a nominee back in,
10 do all the vetting that has to be done with the
11 person and then submit our paperwork through, giving
12 them the thirty-day window.

13 CHANTEL CORBETT: Yeah. The reason I ask, some
14 of the societies only meet so many times a year. I
15 wasn't sure how that would fall into their meetings
16 cycle.

17 JAMES FUTCH: Brenda, we would probably prefer
18 wouldn't we, if they're having their society
19 meetings in May, April, March, spring meeting,
20 right? If, if they were to go ahead and talk to the
21 society that nominated them and maybe get the ball
22 rolling so we don't have to go after the fact and
23 send something out. We can get something from them.

24 CHANTEL CORBETT: That's why I --

25 BRENDA ANDREWS: Right now we're pretty much

1 after the fact.

2 JAMES FUTCH: We don't want to be.

3 BRENDA ANDREWS: We don't want to be.

4 CHANTEL CORBETT: It's not easy. I know.

5 BRENDA ANDREWS: We really need to go ahead and
6 get some nominees in at this point.

7 CHANTEL CORBETT: Like FNMT, we have our
8 meeting the 30th of this month. Council meeting.
9 Our annual meeting is in May. We have another
10 council meeting at the beginning of the meeting in
11 May, so at that point, we can make sure we have a
12 decision or whatever.

13 BRENDA ANDREWS: I'm pretty sure the Department
14 is going to want us to have something before the end
15 of this year. Some decision made.

16 CHANTEL CORBETT: We'll talk about it.

17 BRENDA ANDREWS: Because we have one that will
18 be open, well, from February and May.

19 CHANTEL CORBETT: FNMT will be a good guide --

20 BRENDA ANDREWS: I appreciate that, too.

21 CHANTEL CORBETT: -- Society both and see if we
22 can come up with a nuclear med position for you --

23 BRENDA ANDREWS: I would really appreciate
24 that.

25 CHANTEL CORBETT: Because they are harder.

1 BRENDA ANDREWS: Right. It's the keeping up
2 with letters going out --

3 CHANTEL CORBETT: Right.

4 BRENDA ANDREWS: -- responses coming back and
5 e-mails and sometimes, you know, you don't know
6 whether someone has responded back to you or not for
7 a while because you've got other things going on.

8 CHANTEL CORBETT: Right.

9 BRENDA ANDREWS: Before they start asking me a
10 whole lot of questions, I have already been
11 contacted that we have positions vacant. So I know
12 they want them to be filled pretty soon. So I'm
13 thinking at least by the end of this year those
14 positions will need to be filled. At least by
15 January.

16 CHANTEL CORBETT: Okay. I'll see what we can
17 do in the next couple weeks.

18 BRENDA ANDREWS: Okay. That would be great.
19 Thank you so much.

20 RANDY SCHENKMAN, CHAIRPERSON: what I was just
21 saying is because we have so many positions that are
22 going to be opening up in July, that maybe letters
23 to all the members of the board to see if they want
24 to return maybe should go out in April or beginning
25 of May, so that that gives everybody time to -- that

1 would give time for the spots to be re-filled.

2 BRENDA ANDREWS: And probably before that, I'm
3 thinking.

4 RANDY SCHENKMAN, CHAIRPERSON: Or before that.

5 BRENDA ANDREWS: It will have to be. Because
6 if I -- if they are in -- if their terms are going
7 to end, well, July, a lot them will end -- let's see
8 here. Yeah. Those that are ending in July. Let's
9 see. Yeah, April will probably be a good time.
10 April, May, June. Yeah, April would be a good time
11 to put those notices out. Okay. That would be
12 great.

13 RANDY SCHENKMAN, CHAIRPERSON: So most of us be
14 looking for your notices in April.

15 BRENDA ANDREWS: I will definitely put that in
16 my outlook.

17 RANDY SCHENKMAN, CHAIRPERSON: Okay. Is there
18 anymore discussion on this? Should we go on?

19 okay. The next thing we have is old business.
20 Is there anything anybody wants to bring up about
21 old business?

22 (No Response)

23 RANDY SCHENKMAN, CHAIRPERSON: Nope? Okay. So
24 now we're going to move on.

25 Our next meeting --

1 BRENDA ANDREWS: There's calendars.

2 RANDY SCHENKMAN, CHAIRPERSON: There's a
3 calendar in the back.

4 BRENDA ANDREWS: Yeah, in the back.

5 RANDY SCHENKMAN, CHAIRPERSON: So give us an
6 idea what we're thinking when the next meeting
7 should be.

8 BRENDA ANDREWS: I printed three of them,
9 March, April and May. That was just to have
10 something to look at because we generally go around
11 the May time frame. If you all want to continue to
12 stick with that with May, that will narrow it down
13 to that month.

14 JAMES FUTCH: When is CRCPD, do you know? I
15 hear you.

16 KATHY DROTAR: May would put us after the
17 session ends. The legislative.

18 JAMES FUTCH: Oh, it's January, February this
19 year, right? It's the early year.

20 RANDY SCHENKMAN, CHAIRPERSON: So is May okay
21 with everybody?

22 JAMES FUTCH: So we need to avoid the week of
23 May 20th, 21st.

24 BRENDA ANDREWS: Okay. What's during that
25 week?

1 JAMES FUTCH: CRCPD. Any other societies we
2 know of now meeting?

3 CHANTEL CORBETT: ARRT is the first weekend.
4 That won't affect the Tuesday.

5 RANDY SCHENKMAN, CHAIRPERSON: So the -- we
6 have to avoid the 21st -- the 22nd you're saying?

7 JAMES FUTCH: Yep.

8 RANDY SCHENKMAN, CHAIRPERSON: Okay.

9 STRATIS LAGOUTARIS: One second. This calendar
10 is incorrect. May -- this is May 18th, I'm sorry,
11 like May 16th is actually a wednesday, not a
12 Tuesday.

13 BILL ATHERTON: well, there's two 16's.

14 BRENDA ANDREWS: I think it's the way it looks.

15 STRATIS LAGOUTARIS: I picked one day with two
16 16s. Got it. Never mind everybody.

17 CHANTEL CORBETT: Those numbers are really
18 blurred.

19 BRENDA ANDREWS: The fives look like sixes.
20 The fives look like sixes.

21 KATHY DROTAR: The 15th?

22 RANDY SCHENKMAN, CHAIRPERSON: So our choices
23 are the 1st, the 8th, the 15th and probably the 29th
24 is not good. It's right after Memorial Day.

25 So anybody have a preference for any of the

1 first three weeks? First three Tuesdays?

2 KATHY DROTAR: The 15th.

3 CHRISTINE CRANE-AMORES: The 15th.

4 RANDY SCHENKMAN, CHAIRPERSON: Okay. Is the
5 15th good for everybody so far?

6 JAMES FUTCH: Any complications with schools,
7 colleges, children's schools?

8 KATHY DROTAR: Not as of today at 3 o'clock.

9 CHANTEL CORBETT: Usually May is Memorial Day.

10 RANDY SCHENKMAN, CHAIRPERSON: So May 15th it
11 is.

12 BRENDA ANDREWS: Okay. And the location?

13 KATHY DROTAR: Here.

14 RANDY SCHENKMAN, CHAIRPERSON: Does everybody
15 like it here? We have here and we've done Orlando.

16 BRENDA ANDREWS: Yes.

17 MARK SEDDON: This is fine.

18 JAMES FUTCH: All the east coast folks would
19 like to go back to Orlando. No. We're agnostic in
20 Tallahassee. It's the same time frame either way.

21 RANDY SCHENKMAN, CHAIRPERSON: So if it's okay
22 with everybody, why don't we just do it here? This
23 was very easy. Is that okay? Does somebody have a
24 preference for Orlando?

25 STRATIS LAGOUTARIS: It doesn't matter.

1 RANDY SCHENKMAN, CHAIRPERSON: Is this good for
2 you?

3 ADAM WEAVER: May 15th?

4 RANDY SCHENKMAN, CHAIRPERSON: May 15th, here.

5 BRENDA ANDREWS: So that's that.

6 RANDY SCHENKMAN, CHAIRPERSON: So does anybody
7 else have anything else before we adjourn?

8 BRENDA ANDREWS: I want to say one more thing
9 about the travel.

10 RANDY SCHENKMAN, CHAIRPERSON: Ah, yes.

11 BRENDA ANDREWS: The dirty words.

12 JAMES FUTCH: we'll start with "we apologize".

13 BRENDA ANDREWS: Yes, we apologize all around.
14 Some of you got in very easily this time, but we
15 still have glitches in that system. My plan is to,
16 since we now know the date of the next meeting, to
17 go ahead and do the Go Travel electronic system and
18 try and get your travel through. That gives us
19 about six months or more to get everybody approved
20 through their preferred system.

21 So you can look for an e-mail that's going to
22 say, do not reply from this -- DOH, very shortly.
23 Probably within a month because I'm going to go
24 ahead and try and get these done this time and not
25 be at the last minute.

1 No matter how soon I started, it seemed to
2 wind up at the last day trying to get travel done.
3 And we don't want to keep doing that. So we're
4 going to give this another try. We'll give it more
5 time.

6 RANDY SCHENKMAN, CHAIRPERSON: Are there any
7 receipts or anything you need from us for that might
8 not have gone through or --

9 BRENDA ANDREWS: If you -- well, everybody's
10 went through. I actually -- this is my fault. I
11 messed up and didn't know that Alberto was coming,
12 so I've got to go back and actually do travel for
13 him. So if you have receipts, like tolls or your
14 hotel receipts and anything, you can all send those
15 back to me or e-mail me copies. Make it easy for
16 yourselves. Okay.

17 RANDY SCHENKMAN, CHAIRPERSON: But if we've
18 already had the approval, do we still need to do
19 that?

20 BRENDA ANDREWS: If you've already had the
21 approval, you still need to e-mail me receipts
22 because I need to attach those to your
23 reimbursement.

24 RANDY SCHENKMAN, CHAIRPERSON: Okay.

25 BRENDA ANDREWS: And you don't have to mail

1 them back. You can scan those in and e-mail them to
2 me. That will be fine.

3 BILL ATHERTON: And then fill in the exact
4 times and stuff on -- is that online now or --

5 BRENDA ANDREWS: If your times are different
6 from what was on the authorization, just in your
7 e-mail, tell me what your times were.

8 BILL ATHERTON: Gotcha.

9 BRENDA ANDREWS: Your exact times. And if your
10 mileage was different, tell me what your exact
11 mileage was and I'll adjust it. Of course, you know
12 that the way the state works is I have to do the
13 rental car based on their criteria as opposed to the
14 actual mileage at the 0.445 cents per mile. And
15 they give what is the most economical for the state,
16 of course.

17 CHANTEL CORBETT: what?

18 BRENDA ANDREWS: Yes, I'm sorry.

19 RANDY SCHENKMAN, CHAIRPERSON: Gee, what a
20 surprise.

21 CHANTEL CORBETT: Shocking.

22 BRENDA ANDREWS: Yeah. It makes my heart break
23 to even say some of these things. That's the way
24 they do it. That's the way it is. So anyway,
25 that's how it's figured. So any receipts, you can

1 just e-mail those back to me and that will be fine.

2 RANDY SCHENKMAN, CHAIRPERSON: Any other
3 questions? Comments? Okay. I think we're
4 adjourned. And we'll see each other again in May.

5 (Proceedings recessed at 2:19 p.m.)

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CERTIFICATE OF REPORTER

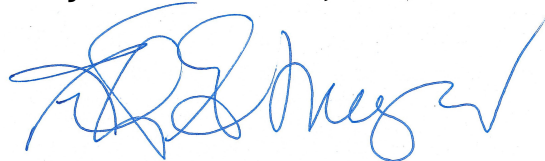
STATE OF FLORIDA:

COUNTY OF HILLSBOROUGH:

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 10th day of October, 2017.



RITA G. MEYER, RDR, CRR, CRC

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