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3	ADVISORY
4	COUNCIL ON
5	RADIATION PROTECTION
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7	CERTIFIED
8	TRANSCRIPT
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11	Bureau of Radiation Control
12	Hampton Inn & Suites
13	Tampa Airport Avion Park Westshore
14	Tampa, Florida 33607
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18	Thursday, December 2, 2021
19	10:01 a.m 2:41 p.m
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21	Reported by Rita G. Meyer, RDR, CRR, CRC
22	Realtime Reporter and Notary Public State of Florida at Large
23	State of fiorida at harge
24	<b>AGR</b>
25	ALL GOOD REPORTERS

1 ADVISORY COUNCIL MEMBERS PRESENT:

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2
      Randy Schenkman, M.D., Retired (Chairman)
      Mark S. Seddon, M.P., DABR, DABMP (Vice-Chairman)
 3
      Rebecca McFadden, RT(R)
      Nicholas Plaxton, M.D.
 4
      Adam Weaver, MS, CHP
      Mark Wroblewski
 5
      Chantel Corbett, AS, CNMT, RT (N), RSO
      George Gilbride, R.R.A, R.T. (R) (CT) (ARRT)
      William "Bill" Atherton, DC, DACBR, CCSP
 6
      Joseph Danek, CHP
 7
 8
     FLORIDA DEPARTMENT OF HEALTH STAFF
 9
      Cynthia Becker, Bureau of Radiation Control
      James Futch, Bureau of Radiation Control
10
      Clark Eldredge, Bureau of Radiation Control
      Douglass Cooke, Bureau of Radiation Control
      Giovanna Manning, Bureau of Radiation Control
11
      John Williamson, Bureau of Radiation Control
12
13
     SkinCure Oncology Presenters:
14
     Dr. Lio Yu, Radiation Oncologist
     Steven Scott, Chief Operating Officer
15
     Joshua Swindle, Director of Practice Operations
16
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1 DR. RANDY SCHENKMAN: Welcome everybody to our 2 real live meeting for a change. A good change, we 3 So everybody can get to know each other, why hope. 4 don't we start with everybody introducing 5 themselves. Do we want to start with you? STEVEN SCOTT: Do you want to introduce 6 7 yourself? 8 I'm Dr. Lio Yu, radiation DR. LIO YU: Yes. 9 oncologist. I work in New York. It's nice down 10 here. 11 (Laughter) 12 STEVEN SCOTT: I'm Steven Scott. I'm the chief 13 operations officer for SkinCure Oncology. 14 JOSEPH DANEK: I'm Joe Danek. I'm on the 15 Advisory Council for expert environmental matters. 16 GIOVANNA MANNING: I'm Giovanna Manning. I'm 17 an environmental specialist for the Bureau. Tallahassee. 18 19 GAIL CURRY: I'm Gail Curry. I'm with medical 20 quality assurance. We do the licensing for all the 21 radiologic technologists. 22 MR. COOKE: Good morning. I'm Douglass Cooke. 23 I'm the substitute Brenda. 24 JAMES FUTCH: Who's our administrative 25 assistant for the Council.

I'm James Futch, Bureau of Radiation Control. 1 2 Also based in Tallahassee and I'm council leader. 3 DR. RANDY SCHENKMAN: Randy Schenkman, Board 4 certified radiologist and the chairperson here. 5 CINDY BECKER: Hi. Cindy Becker. Good I'm the Bureau Chief for Radiation 6 morning. 7 Control. MARK SEDDON: Mark Seddon. I'm a medical 8 9 physicist with Advent health and the vice-chair. 10 CLARK ELDREDGE: Clark Eldredge, Florida 11 Department of Health. I'm the administrator for the 12 radiation machine section. GEORGE GILBRIDE: George Gilbride. 13 I'm retired 14 but I'm a certified radiologist assistant and 15 retired from the University of Florida. 16 WILLIAM ATHERTON: Bill Atherton. I'm a 17 chiropractic radiologist in Miami, Florida and I wish I was retired. 18 19 (Laughter) 20 REBECCA McFADDEN: I'm Rebecca McFadden. T'm 21 the certified radiologic technologist on this 2.2 committee. 23 DR. NICHOLAS PLAXTON: I'm Dr. Nicholas 24 Plaxton. I'm a nuclear medicine physician at the 25 Bay Pines VA.

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

3 DR. RANDY SCHENKMAN: Okay. Well, welcome 4 everybody. And we're going to really have -- it 5 looks like this is going to be a fun day, especially 6 when we get to after lunch.

7 While I'm bringing up lunch, if it's okay with everybody, we were going to shorten lunch from maybe 8 9 12 to 1, because two of us have -- we're from Miami 10 and our flights are at 3:10, so we're going to have 11 to leave early. So if that's okay with everybody, 12 we'll just shorten it a little bit. Okay? 13 DR. NICHOLAS PLAXTON: Sounds good. 14 DR. RANDY SCHENKMAN: Okay. Now we have --

15 anybody have something to say?

16 ADAM WEAVER: No.

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

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

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

DR. RANDY SCHENKMAN: Okay.

7

3 JOSEPH DANEK: So I don't know. That's all I9 got.

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

14 JAMES FUTCH: If I can add to that. So Brenda, 15 your comments were the very last ones that she got 16 and she incorporated those. And that's actually 17 what's posted right now on the website is the 18 unadopted minutes. And we have a physical copy here 19 if anybody wants to look at it. I think we got 20 several comments internally from staff about a lot 21 of different areas. My staff. And then we had a 22 couple council members mentioned corrections to 23 their sections.

24 JAMES FUTCH: Okay. So we'll take a vote on 25 approval of the minutes. All in favor, aye?

1 ALL: Aye. 2 DR. RANDY SCHENKMAN: Any opposed? 3 (No Response) 4 DR. RANDY SCHENKMAN: Okay. We're passed. 5 Okay. Cindy? CINDY BECKER: Okay. Well, as far as the 6 7 Bureau updates, I'll get to that. But we wanted to wish Dr. Schenkman a happy, happy birthday. 8 9 DR. RANDY SCHENKMAN: Thank you. 10 CINDY BECKER: And we're so pleased that her 11 family allowed her to share her special day with us. 12 REBECCA McFADDEN: Happy birthday. 13 (Applause) 14 CINDY BECKER: And we brought some little 15 Cuban, little snacks, pastries over here if anybody 16 would like them. 17 JAMES FUTCH: And cheese. CINDY BECKER: There's different kinds of cream 18 19 Feel free to have that. And we have cheese, quava. 20 to give a little candle. Now this is -- who wants 21 to do the honors? 22 JAMES FUTCH: You do. 23 CINDY BECKER: Okay. What kind do you like, 24 Dr. Schenkman? What kind do you like? 25 DR. RANDY SCHENKMAN: I'll take one of the ones

1 with the guava in it. The red ones. 2 CINDY BECKER: Okay. Well --3 DR. RANDY SCHENKMAN: That's so nice. 4 CINDY BECKER: She gets the candle all herself. 5 JOSEPH DANEK: Guava. I'm from Miami. I like 6 the guava. 7 CINDY BECKER: You can tell I'm not used to doing this. Okay. So should we embarrass her and 8 9 try to sing? 10 GIOVANNA MANNING: Yes. 11 REBECCA McFADDEN: If we're going to do it, 12 let's do it. 13 (Singing Happy Birthday) 14 DR. RANDY SCHENKMAN: Thank you all so much. 15 (Applause) 16 DR. RANDY SCHENKMAN: I'm going to make a wish. 17 DOUGLASS COOKE: Speech, Speech. WILLIAM ATHERTON: Meeting is adjourned. 18 19 (Laughter & Applause) 20 DR. RANDY SCHENKMAN: And you're all included 21 in my wish. 22 CINDY BECKER: Nice. 23 JOSEPH DANEK: That's not going to be in the 24 minutes, is it? 25 DOUGLASS COOKE: Every key and every note that

9

1 was sung.

2 CINDY BECKER: As you can tell, the new people 3 that are here, we become like family after many 4 years of serving together on the Board. And so, we 5 look forward to many more years. Yay. DR. RANDY SCHENKMAN: Sounds good. 6 7 CINDY BECKER: Thank you. 8 DR. RANDY SCHENKMAN: Thank you all. 9 CINDY BECKER: So Bureau updates, I'm even 10 afraid to say this. I have to knock on wood. We almost have a full staff. Poor John and his 11 12 environmental section keeps struggling with staff. 13 I think they have almost two vacancies right now. 14 But we have a full licensing staff and we have a 15 full inspection staff, so we're good there. And they've been out and about since the very beginning. 16 17 You know, they took about two weeks off when Covid 18 hit. And I just went out with one of the newer 19 inspectors yesterday. And we said, yeah, they've all done really well. And they haven't had really 20 21 any issues getting into facilities. So all is good 22 there.

23 We'll have some updates, you know, from Clark 24 and from Giovanna. Giovanna's representing the --25 GIOVANNA MANNING: Kevin.

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

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

7 We have an internal applied radiation physics and instant response class where we, over the years, 8 9 when NRC quit offering free training for us, we 10 developed our own in-house training. It's at John's 11 lab facility, which some of you that have never been 12 there, I invite you all to drop by there because 13 it's a beautiful facility. But they have a nice new 14 training facility there. And they're going to be 15 running our newer staff, about 12 of them, through some exercises in the field, learning how to use the 16 17 detection equipment, which you'll see some of that later this afternoon. He'll bring some of our 18 19 newest toys. And they get to play with the toys and 20 get some training on our procedures and processes 21 and it will be a good course. It's a whole week 22 long there at the lab. That's coming up the 13th 23 through the 17th.

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

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

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

8 So other than that, welcome everybody. And 9 we'll move on with the, with the --

10 DR. RANDY SCHENKMAN: Okay. Gail, you're up 11 next.

12 CINDY BECKER: Gail.

13 GAIL CURRY: I'm sorry.

14 CINDY BECKER: Gail. We're going to embarrass15 Gail too now.

16 JAMES FUTCH: All right.

17 CINDY BECKER: It's her last official meeting18 with us. Miss Gail is retiring.

19 REBECCA McFADDEN: Congratulations.

20 GEORGE GILBRIDE: Congratulations. You'll love 21 it.

22 GAIL CURRY: Thank you. I'm excited. I'm very 23 excited.

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

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

6 So Gail's actually been working for the 7 Department since 2002, if I remember right, and she 8 has worked in the Bureau of Radiation Control and 9 then in 2005, when the alliance between our section 10 and MqA happened for the purposes of rad techs, she 11 transitioned over to work for MqA, and she's been 12 there ever since.

13 GAIL CURRY: Not by choice.

14 (Laughter)

15 JAMES FUTCH: Not any of our choices, but that's kind of the way it worked out. So we have --16 17 had Gail working on behalf of the Council in the 18 Bureau doing some of the background stuff before the 19 transition, and then afterwards in the role that you 20 see her now, which is representative and usually interfaced with the educational program members and 21 22 help out whatever technologists or applicants 23 couldn't get licensed or haven't gotten licensed in 24 any way, shape or form.

25 But we just wanted to take a minute and thank

1 Gail for all of her support over the years and with 2 all of you here, and to wish her the best in her 3 retirement soon, next year some time early. 4 GAIL CURRY: February 1st. 5 (Laughter) 6 REBECCA McFADDEN: She's not counting. 7 DR. NICHOLAS PLAXTON: She knows the days. JAMES FUTCH: This one over here has a clock on 8 9 her desk down to the microseconds. 10 But we wanted to give you something to remember 11 us by and hang something on your wall, so we've got 12 a little certificate of appreciation. I'm going to 13 read it and then present it to you. It says 14 "Certificate of Appreciation is hereby awarded by 15 the Bureau of Radiation Control to Gail Curry for her 15 years of excellent service to the Advisory 16 Council on Radiation Protection and its members." 17 18 And we actually have all the current members' names 19 listed down here at the bottom of the certificate. 20 And Dr. Schenkman --21 GAIL CURRY: Nice. 22 JAMES FUTCH: -- and Cindy have signed at the 23 bottom. So if you want to stand up for a picture. 24 (Applause) 25 JAMES FUTCH: I think we'll get something like

1 Face Douglass. And you can take pictures this. with everybody else afterwards if you want to. 2 3 GAIL CURRY: Thank you. 4 Let me just bounce off of that a little bit. 5 This is kind of bittersweet for me because James hired me back in 2002. I knew absolutely nothing 6 7 about any of this. I mean, I didn't even know what a, a BXMO was. He said BXMO and I'm like, I don't 8 9 know what the heck you're talking about. And 10 instead of saying radiography, I would say radio-graphy. So I, you know --11 12 (Laughter) 13 GAIL CURRY: -- it wasn't my world at all. James and --14 15 (Chantel Corbett Enters Meeting) GAIL CURRY: -- and his staff took me under 16 17 their wings and trained me very well. So for that, 18 I'd like to say thank you. 19 JAMES FUTCH: Thank you. 20 GAIL CURRY: They are my family. They're not my work family. They're my family. And I know I 21 22 could call any one of them at any time and say, I 23 need something or if I'm having a rough time 24 personally, they're there for me. 25 So it's going to be hard to leave, but I'm

1 leaving on a good note. And I'm leaving in a good 2 place for myself. So with that, I say thank you 3 very much.

4

So let me just --5 JAMES FUTCH: Back to the real business. GAIL CURRY: Yeah. Let me just give, give 6 7 y'all some numbers like I usually do, and then, you know, I'll open it up for anybody that has questions 8 9 or concerns or anything like that.

10 So I am the regulatory supervisor consultant 11 for radiography, EMT paramedics and nursing home 12 administrators. I will be leaving February 1st. We 13 do have a new supervisor that will be taking my 14 place. Her name is Melanie Smith. She's been one 15 of my processors for about three years, so she knows the backside of the processing; the guidelines 16 17 that's required to license someone, so I think you'll be in really good hands. 18

19 They did do a layover or an overlap to -- so 20 that I could train her and I'm trying to give her all the information that I have so that, you know, 21 22 you guys shouldn't see any major problems or 23 anything like that.

24 So with that being said, I can tell you that 25 right now, we are processing applications two days

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

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

11 There are -- starting January 1st through 12 November 30th, we have -- we've received 2,266 13 applications for general radiographers, which 14 includes nuclear medicine and radiation therapy. We 15 have five radiologic technology assistants. Those are new applications. And we have 85 of the basic 16 17 x-ray machine operators, for a total of 2,356 18 applications received from January 1st until the day 19 before yesterday. So, you know, you guys are 20 growing; looking good.

21 We have also issued certificates. Now, those 22 were just applications received. We've -- we have 23 licensed 2006 general radiographers, 20 nuclear 24 medicine techs, 35 radiation therapy technologists, 25 five radiologic technologist assistants and 61 basic

1

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

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

8 Right now -- and I'm not real sure if these 9 numbers are accurate because sometimes when we run 10 the reports versus IT running the reports, they're 11 not exactly the same, but rad techs, including 12 basics, we're looking at 29,485 active licenses. We 13 have 36 active assistants. So your numbers are, are 14 increasing.

15 JAMES FUTCH: There's one.

16 GAIL CURRY: Yep. That's why I keep looking at 17 him.

18 GEORGE GILBRIDE: I was RA26.

19 (Laughter)

20 GAIL CURRY: With that, I will just open the 21 floor for any questions; concerns. And please, 22 always know -- well, I'll be there until February 23 1st. But anything that we can do to help streamline 24 our process or to make things run smoothly, we're up 25 for changing anything we can. Some things, you

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1 know, my hands will be tied because of IT and things 2 of that nature, but I always love getting new ideas 3 and new things, so --

4 GEORGE GILBRIDE: I have one question.5 GAIL CURRY: Sure.

GEORGE GILBRIDE: In the state, you have to 6 7 keep your, you know, you have to maintain your RT license as well as your RA license. One of the 8 9 things that a few of the people that I worked with 10 up at UF is when we would put in for -- because both 11 licenses are up at the same time. And a lot of 12 times, like for me and also Sean, he had his RT 13 license, which would be, you get the license for it, 14 and my RA license, I have to make a phone call 15 because they didn't tie in my, my CEUs with the RA. So I just made several calls -- and so did Sean --16 17 and I don't know if, I don't know if that happened 18 with Ken Harbor, either. These are some of the 19 other RAs that worked. And it gets resolved, but 20 it's always a matter of making a couple phone calls 21 so just --

22 GAIL CURRY: Okay.

23 GEORGE GILBRIDE: -- they somehow don't have a 24 way to tie them together.

25 GAIL CURRY: Right. And it's two separate

1 licenses. So you have to remember, it's two 2 separate licenses. Just because you renew one 3 doesn't automatically renew the other. 4 GEORGE GILBRIDE: We would send them both in 5 with both of the information. I mean, they would be separate envelopes and we'd get the RT stuff, but 6 7 it's always a call, oh, okay. And it gets resolved. 8 GAIL CURRY: Really? 9 GEORGE GILBRIDE: Yeah. It's just --10 GAIL CURRY: You shouldn't have to make that 11 phone call. It should be done. And I will take 12 that back to the office because that -- and 13 especially if you're sending them in separately, 14 they're separate license numbers. They're different 15 modalities, so you shouldn't have to be making that phone call. And that does not actually come through 16 17 my department. It comes through licensure services. 18 GEORGE GILBRIDE: I'm sorry. 19 GAIL CURRY: No, no, no. What I'm saying is, 20 we ultimately could handle that, but renewals go 21 through a different department. 22 GEORGE GILBRIDE: Okay. 23 So I need to relay this GAIL CURRY: 24 information to them so that that won't happen in the future. Because when you're sending that in, it 25 All Good Reporters, LLC 407.325.0281

20

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

4 CHANTEL CORBETT: Are you uploading your CEUs 5 or sending them in with the paper?

GEORGE GILBRIDE: Uploading them.

7 CHANTEL CORBETT: Do you have to upload them8 twice or only once?

9 GEORGE GILBRIDE: Yes.

6

10 CHANTEL CORBETT: Okay. I was wondering if it11 was only one portal maybe that was messing up.

12 GEORGE GILBRIDE: The last time, it was funny, 13 we were in the midst of moving some equipment and 14 thank goodness, I was, I was, I was on my cell phone 15 and we lost contact and my wife was at our house. We still had the phone working there. 16 And the 17 person called back, got my wife to tell them it's 18 okay, just let them know it will be mailed out 19 properly, because they didn't have my cell phone 20 number.

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

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

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

GEORGE GILBRIDE: Okay.

6

7 JAMES FUTCH: George, when they set this profession -- when they did the transition from 8 9 being a purely Bureau of Radiation Control run 10 profession to an MqA run profession in 2005, they 11 set up all of the radiographers and nuclear med 12 techs, therapists and basic machine operators 13 underneath essentially the same profession number in 14 the licensing database. So it's a little bit easier 15 to handle things on that side. So you can be a nuclear med tech and a radiologist therapist, it 16 17 will all sync up. It will have one license number and it will all renew at the same time. 18

19 Gail's group on the front end on the Board 20 office handles applications and thing like that. 21 There's another group she mentioned, the licensure 22 services, and they're used to dealing with the large 23 volume that comes from all of the rest of the 24 professions. So they key in on the profession 25 number. The number.

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1 When they set the radiologist assistants up, it 2 was, it was a few years after that. And for 3 whatever reason, at that point in time, they set it 4 up in their database as a whole separate profession 5 number. So you get this issue of, we think of it as the same, you know, it should be the same, certainly 6 7 the same person. It should be the same license, but 8 it's handled separately in the, in the system, so we 9 end up having to do stuff like this. But we very 10 much appreciate knowing about it because, you know, 11 we don't know what's happening out there and then it 12 takes a little bit of special --13 GAIL CURRY: Hands off. 14 JAMES FUTCH: -- hands off on the backside to 15 go talk to the right people. GEORGE GILBRIDE: I don't want to get anybody 16 17 in trouble now. GAIL CURRY: No, no, no. 18 19 JAMES FUTCH: It's not that. I wish it was 20 just as simple as going and talking to the people. 21 GAIL CURRY: Let me ask you a question. You said you sent these in by mail. Did you try to do 22 23 them online? 24 GEORGE GILBRIDE: I did them online. GAIL CURRY: You did them online? 25

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

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

6 GEORGE GILBRIDE: I did them online. I 7 uploaded all the information and stuff like that. 8 GAIL CURRY: So you did try to renew them 9 online and it did not renew one of them. That's 10 really --

11 GEORGE GILBRIDE: And I got the verification 12 that it all went through, but I only received one 13 license via mail.

14 GAIL CURRY: Okay.

JAMES FUTCH: It could just be another quirk.GAIL CURRY: Right.

17 JAMES FUTCH: Every once in a while, we come 18 across quirks in the different data systems. But we 19 came across one -- it was kind of part of my update, but ties into this a little bit. We came across one 20 that on the renewal applications, there's a question 21 22 that asks about background history, just like there 23 is on the initial application. If you had a, you 24 know, conviction; this kind of thing. And if you 25 answer yes to it, then you have to supply a bunch of

1 additional information. It was designed that way; 2 it was working that way. There's only one problem. 3 If you have two convictions to report --4 GAIL CURRY: You'd be surprised. 5 JAMES FUTCH: -- the system gets a little wonky 6 on the last one that you answered, so we've got, as 7 you say, a ticket in to IT to fix that. 8 REBECCA McFADDEN: I'm thinking, you know, as 9 it only allows you to have one copy of a license, it 10 could be some of the configuration and that's based 11 on, you know, you're only going to generate one per 12 person, even if there's multiple licensures. You 13 see what I mean? Maybe that could be something to 14 look at from an IT perspective. 15 GAIL CURRY: Right. And that should not be happening, but that could be a good scenario. 16 17 REBECCA McFADDEN: Right. 18 GAIL CURRY: Because there's two separate 19 license numbers or certificate numbers. 20 REBECCA McFADDEN: Yeah. 21 GAIL CURRY: So it shouldn't be doing that. 22 REBECCA McFADDEN: Some of them may be. 23 GAIL CURRY: It could be. That's a very good 24 observation. 25 JAMES FUTCH: Kathy couldn't be with us today.

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1 Dr. Drotar. Normally she has a few questions about 2 the many Keiser classes graduating and issues that 3 have happened with them. 4 GAIL CURRY: I haven't heard from her for a 5 while. JAMES FUTCH: Yeah. 6 7 GAIL CURRY: We're doing good. JAMES FUTCH: It's working well. 8 9 REBECCA McFADDEN: No news is good news. 10 GAIL CURRY: I'm actually looking at your file 11 and I do see where you did this back in May. May 15. 12 I feel so naked now. GEORGE GILBRIDE: Mm-hmm. 13 GIOVANNA MANNING: You're exposed. 14 (Laughter) 15 GEORGE GILBRIDE: Oh, God. 16 DR. RANDY SCHENKMAN: Hide. 17 JAMES FUTCH: We're recording this for 18 publication on the website. Everybody feel free to 19 say whatever you want. 20 REBECCA McFADDEN: This is public record, 21 right? 22 GAIL CURRY: So I -- just by looking at this, 23 everything looks like it went through okay, and both 24 the certificates printed for you on 5-15. Why it 25 didn't get to you, I'm not sure, but I will

1 definitely look into that.

2 CHANTEL CORBETT: I was going to say, is your 3 address the same on both?

GEORGE GILBRIDE: Yes.

4

5 CHANTEL CORBETT: Some people put a practice 6 address on one and a house address on the other.

GEORGE GILBRIDE: No, they're both the same. I
can doublecheck on that. No, they're both the same.
CHANTEL CORBETT: Because we have a lot of
techs who forget they put their practice address on
it and it goes to a hospital somewhere.

12 GEORGE GILBRIDE: No, they're both the same. 13 GAIL CURRY: It gets lost in that big -- yeah, 14 they both are the same in the system, so -- but 15 yeah, that's a great point and I'll be glad to take 16 that back for you.

17 GEORGE GILBRIDE: And like I said, it just 18 didn't happen to me. It happened to a few other 19 people. I don't know if it's just -- again, I just 20 don't know why, but I haven't heard from anybody 21 else. But I don't really deal with too many of the 22 people other than these other two individuals that I 23 worked with.

24 GAIL CURRY: Yeah. And I may reach out to you 25 for those names just so I can look at the files and

1 have some more information to give to IT. 2 GEORGE GILBRIDE: Sure. 3 GAIL CURRY: And then that way, they can look 4 at all those --5 GEORGE GILBRIDE: No problem. GAIL CURRY: -- and see if there's a common 6 7 ground somewhere that will cause that to happen. 8 GEORGE GILBRIDE: Okay. No problem. GAIL CURRY: Thank you. 9 10 GEORGE GILBRIDE: You're welcome. 11 DR. RANDY SCHENKMAN: Anybody have any other 12 comments or questions or anything? 13 JAMES FUTCH: Does anyone see any changes 14 coming from your societies for the professions in 15 terms of nationally, standards changing, things need to change in Florida, or they're not, anything like 16 17 that? Everybody's happy? 18 (Laughter) 19 REBECCA McFADDEN: There was a change, I mean as far as, I don't know, it's not a national 20 21 society, but I was part of the big society, 22 radiologist technologists that operated out of 23 We had as many members as our Florida state Ocala. 24 as far as registered technologists. We did the --25 post the pandemic, we did dissolve that society so

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

But we did, we did dissolve the society and so, 8 9 but you know, a lot of -- we did, we -- with the 10 funds at the end, we donated to our -- the school, 11 the local school that is run by Marion County School 12 And that was, you know, but after the Board. 13 pandemic and, you know, inability to meet for such a 14 long time, and then, you know, the willingness to 15 get speakers was getting harder and harder. We had about 75 people attend our yearly seminar on a 16 17 Saturday. It was just a one day. But it's 18 definitely going to be something that's missed in 19 our area and I'll miss, you know, for sure.

20 But we did have to make that decision and no 21 longer keep it going. It's the online environments 22 I think and more opportunities for CEUs that way. 23 So sad, but --

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

1 session in January, it's the early year. We keep feelers out to try and see things that might be 2 3 happening, bills that will affect the radiation 4 issues. But if you hear something, if you -- in 5 your facilities, with your contacts and, and your peers with the societies, if there's something you 6 7 hear rumblings of, let us know and we'll make sure we keep a watch out for it. 8

9 Gail, just out of curiosity, EMTs and 10 paramedics are roughly double the number of licensed 11 folks?

12 GAIL CURRY: Yeah. They're almost triple your 13 licenses.

14 JAMES FUTCH: Really? Okay.

15 GAIL CURRY: They're huge.

16 MARK SEDDON: I have a question. So the 17 medical physicists licensure, is that through you, 18 Gail?

19 GAIL CURRY: It is.

20 MARK SEDDON: Okay. So there's some discussion 21 about licensure for or pathways for physicists who 22 are MR certified physicists. I'm not sure if you 23 had any discussion with the folks at Mayo about 24 that.

25 GAIL CURRY: I have not heard anything on that.

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

3 MARK SEDDON: Right.

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

7 MARK SEDDON: Okay. Yeah. So just, just make a note that there's been some discussion, there's a 8 9 pathway for a subgroup of diagnostic physicists who 10 are certified by the -- in MRI only. So they don't 11 fall under the current categories we have as far as 12 diagnostic therapy and nuclear medicine and so they 13 don't have a pathway to become licensed in Florida. 14 And so, it is for some employers who are requiring 15 their clinical physicists to be licensed, they don't really have a pathway for them to move forward. 16

17 So it's not a huge group of folks. It's just 18 those who are specialized in MRI. Because they're 19 typically not certified in diagnostic. They're 20 certified in MRI and physics only. So there's been 21 some discussion amongst the board or the chapter, 22 Florida chapter about what pathways or opportunities 23 could be available to them.

24 CHANTEL CORBETT: Is there only one certifying25 body for that?

MARK SEDDON: For MRI? Yes, there's ABMP. 1 2 That's the only one? CHANTEL CORBETT: 3 MARK SEDDON: Yeah, that's the only one. But 4 we have -- there's a couple physicists, not many, 5 that are in Florida who are MRI-only certified, so they can't become licensed in -- I think Mayo is the 6 one facility that says, well, you have to be a 7 licensed physicist. 8 9 CHANTEL CORBETT: There's a lot of, especially 10 with all the credentialing nowadays. 11 MARK SEDDON: Credentialing -- with the 12 hospitals, you have to have a license to work --13 CHANTEL CORBETT: Right. 14 MARK SEDDON: -- but there's no way for them to 15 become licensed. JAMES FUTCH: What's the situation in other 16 17 states? Has anybody else created a license just for 18 them? 19 MARK SEDDON: No one else has that. So I did a 20 query around the country. There's some other states 21 that have medical physicists licensure. Nobody has 22 an MRI pathway, so it is kind of unique. Then it's 23 a small subgroup. So again, physics is a small 24 subgroup. 25 JAMES FUTCH: Obviously, this is outside the

1 legislation that we would typically look at. The certifying practicing act. Have you looked at the 2 3 definitions there and is it exclusive of 4 nonionizing? I haven't looked at it. 5 MARK SEDDON: No. The closest would be diagnostic medical physicist as an affiliated 6 7 category. But they are not trained. They, they wouldn't include the same scope as far as how it's 8 9 currently written. Because usually, if you're an 10 MRI physicist, you're non-ionizing only. 11 JAMES FUTCH: You would think categories as 12 written in the statute would be so robust as to not 13 allow it if they were inclined to do so with 14 regulations and the lawyers were agreeable to it. 15 MARK SEDDON: Um, I mean, the only -- this is speaking from my opinion. I don't know if this --16 17 my opinion would be that --18 JAMES FUTCH: Sure. 19 MARK SEDDON: -- MRI should be in its own 20 separate category. It doesn't cross over. Τf 21 you're a licensed diagnostic physicist, then it kind 22 of includes you in mammography and some other areas 23 that typically MRI physicists wouldn't be aware or 24 have that knowledge base. So, I mean, we can't have 25 that problem with -- when you categorize specialties

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

4 You know, it would be like if you, if you 5 categorized every type of physician because your license says radiologist only or as a radiation 6 oncologist only, then crossing over those gray area, 7 like, radio pharmaceutical therapy. Like, what is 8 9 that? A radiology practice or is that an oncology 10 practice? It's the same type of thing you have 11 going on within medical physicists.

12 CHANTEL CORBETT: Yeah, I mean obviously, 13 nuclear spectrum has its own license, but it's still 14 within the ionizing radiation.

15JAMES FUTCH: Yeah. So on -- it could come16down to just how strictly that statute's written.

17 MARK SEDDON: Yeah. So we need to review the 18 statute and look at it. I just wanted to ask if you 19 had any, any discussion about it.

20 GAIL CURRY: Yeah. No, I have not.

21 MARK SEDDON: Yeah. There's not really a 22 council, so I think I would primarily go to you with 23 those questions.

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

1 anything like that.

2 MARK SEDDON: Okay. Well, there's some 3 discussion about that.

4 GAIL CURRY: Yeah. That's a good --5 MARK SEDDON: There you go. GAIL CURRY: I will go back and ask, though. 6 7 MARK SEDDON: Okay. Thank you. Going back to the rad techs for a 8 JAMES FUTCH: 9 second. We had a little dalliance with an MR 10 certification.

11 MARK SEDDON: I remember that.

12 It fit the national structure. JAMES FUTCH: 13 And on first glance, the lawyers who looked at it 14 for creating a license category said yes and then 15 after we issued, I forgot how many of them, a year or two later, somebody complained and they looked at 16 17 the same statute and said, no, you can't do that. So then we recalled all those MR licenses for rad 18 19 techs.

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

1 Florida.

2 So the last time we had our legislation 3 changed, we created a category which we called 4 specialty technologists, which allows for us to, 5 essentially, if there is a change at the national level with regard to, you know, a new category of 6 7 radio -- any kind of ionizing stuff, we can put that in by regulation without having to go back to the 8 9 Legislature. Unfortunately, we didn't get the 10 definition of radiation changed to include 11 non-ionizing, so MR is still out at our level as 12 well as ultrasound. 13 Is that it? 14 GAIL CURRY: That was hard for us to explain

15 to, to the people that called when they couldn't 16 renew their MR licenses, or certificates. They were 17 like, what do you mean I can't, you know. And so, 18 we had to explain to them that it was pulled back.

19 They liked having that.

20 JAMES FUTCH: Yeah.

21 GAIL CURRY: They liked having that.

JAMES FUTCH: It's one of those things that makes sense from the medical and patient point of view. And I think if there was enough demand to change the statute, to put it in, you know, we can
1 do it, but it takes some effort. 2 GAIL CURRY: That's all for me. 3 DR. RANDY SCHENKMAN: Anybody have anything 4 else? Okay. We're going to move on to Giovanna. 5 JAMES FUTCH: Giovanna? Who's that? GIOVANNA MANNING: Okay, guys. Again, I'm 6 7 Giovanna. I've been with the Bureau for a little over a year. It was God sent that I got the job. 8 9 Thank you guys again for hiring me. I learn 10 something new every day. Kid you not. 11 But from the last meeting you guys discussed, 12 we're fully staffed, as Cindy said earlier. But vou 13 quys -- I quess Kevin mentioned an inspector review 14 position that was open, but he couldn't give you 15 guys a name. His name is Matthew Sension (ph). He's from the Orlando office, which he moved up to 16 17 the Tallahassee office in our department. But he was -- he's been with the Bureau for over seven 18 19 years and he was one of the duty officers with the, 20 with the Bureau. 21 And then Meghan Thorpe, she was our last 22 evaluator, licensed evaluator that came on board. 23 And she got married, so now her name is Meghan 24 Helms. 25 And the rule making process is still in, in

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

We also -- I'm not sure, you know, how this 6 7 applies to anyone in here, but just an FYI. We were getting some licensees who were -- their license was 8 9 expired and they were still trying to get RAM from 10 And the pharmacies was actually giving pharmacies. 11 it to them. So we just came out with a new fixed 12 paragraph for the cover letter for any pharmacy 13 that, you know, let them be aware that we are, like 14 licensees are amending their license frequently and 15 if they're ordering to try to do a more frequent ask for them to give them up-to-date license. 16

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

21 GIOVANNA MANNING: Original issue.

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

24 GIOVANNA MANNING: Exactly.

25 JAMES FUTCH: -- before it reaches its

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1 expiration date.

2	GIOVANNA MANNING: Exactly, or they had
3	multiple amendment requests in between and not
4	getting an up-to-date license.
5	(Phone ringing)
6	JAMES FUTCH: George is providing the reminder,
7	on the cell phones, to silence those.
8	GIOVANNA MANNING: Silence those.
9	GEORGE GILBRIDE: Sorry.
10	JAMES FUTCH: That's okay.
11	CHANTEL CORBETT: Yeah, I mean, it's
12	interesting because Xofigo, specifically Cardinal,
13	has every six months, they email every licensee that
14	is issued for Xofigo for a copy of the most
15	up-to-date amendment. And they tell you, this is
16	the amendment we have on file. If you haven't if
17	this is the last one, just let us know. If not,
18	send us the new one. So if they everybody would
19	get on that.
20	GIOVANNA MANNING: Yeah.
21	MARK SEDDON: I think they're the only ones I'm
22	aware of that usually request it.
23	CHANTEL CORBETT: Otherwise?
24	MARK SEDDON: Yeah. I don't know of any
25	other

1 CHANTEL CORBETT: No. I agree. 2 MARK SEDDON: -- any other that submit pharmacy 3 requests --

4 CHANTEL CORBETT: Unless it's getting ready to 5 expire, which is what made me question that because 6 I mean, even on an original issue licensure, your 7 expiration date doesn't change even though the 8 amendment is in use --

9 GIOVANNA MANNING: Exactly.

10 CHANTEL CORBETT: -- so they should at least 11 catch that.

12 GIOVANNA MANNING: So, well, me personally, I 13 would say, acts every three months, like every 14 quarter.

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

18 GIOVANNA MANNING: Going in and out.

19 CHANTEL CORBETT: Yeah. Smaller, not as much. 20 JAMES FUTCH: I think that was -- what I heard 21 about it, it was kind of surprising. You spend all 22 the time and effort to make sure someone is 23 qualified with the license initially and then when 24 they renew it, you think everybody is following it

25 and paying attention to all of it. It's like,

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

3 So -- and the funny part GIOVANNA MANNING: 4 was, the licensees who was expired, they were, they 5 were doing a change of ownership in the meantime and the change of ownership had their application in. 6 7 And you know, they were like, we need RAM. We're like, well, you can't get RAM. And, you know, we 8 9 had to issue the new license, but then the RSO is the same RSO for the new licensee. So who was 10 11 responsible to make sure everything is up to date 12 and all that. Yeah. That, that ball dropped so 13 much. So -- but that's something new, which I'm 14 glad that in -- it's now affixed to the pharmacy 15 cover letters. Any other questions pertaining to that? 16

17 I have one more statement and then -- medical 18 events, there was one since the last meeting. Ιt 19 was a gamma knife edition. Well, it was a gamma 20 knife licensee. Apparently, if I'm saying it right, 21 there was, like, double the dose, the maximum dose 22 given within the three months' gap, I'm assuming. 23 Whereas this was out of town and they didn't get 24 the, you know, the out of state, they didn't get the records in time to review, so -- but that was --25

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1 JAMES FUTCH: Yeah. This one, do you remember 2 this one?

CINDY BECKER: I remember this one, yeah. 4 JAMES FUTCH: The patient had, essentially, two 5 facilities involved. And the responsible folks at the facility reached out to get the records from the 6 7 previous ones.

8 GIOVANNA MANNING: Right.

9 JAMES FUTCH: And I think they went on 10 vacation.

11 CINDY BECKER: Right. The treating physician, 12 I guess, left on vacation.

13 JAMES FUTCH: The person who was filling in, I 14 don't have the exact details, didn't realize it, 15 didn't check when they had it treated and the records came in and said, oh. 16

17 GIOVANNA MANNING: Whoops.

18 JAMES FUTCH: Already treated for that not too

19 long ago.

3

20 GIOVANNA MANNING: Yeah.

21 JAMES FUTCH: Hence the double dose.

22 GIOVANNA MANNING: Hence the double dose.

23 One more thing I'm going to CHANTEL CORBETT:

24 bring up on the radioactive materials section side.

25 So, recently, the Department started asking all

1 PET licensees, on any routine amendments, renewals, 2 or a new license, to submit either a shielding 3 design or measurements to prove that the public is 4 protected from radiation. So obviously, with new 5 licensees, there's not an issue because they've got The problem comes in with 6 a new shielding design. 7 the older licensees, where most of them probably had one done, but, they don't have a clue as to where 8 9 they are anymore.

10 So we've been trying to work with everybody up 11 there to get a routine, easy, across-the-board 12 answer of, what do you do? What do you need us to 13 submit for these clients. So as of yesterday, I 14 think was our last conversation. Basically, they 15 want measurements showing with injected F18 patients in the incubation rooms, your nearest point what 16 17 those survey measurements would be to prove that 18 you're not -- I asked for the regulation that we're trying to, all of a sudden, ask for these things 19 20 for, and it was the general radiation protection of the public. So it's -- I feel kind of like we've 21 22 always done similar things with our MOP. 23 GIOVANNA MANNING: Right.

24 CHANTEL CORBETT: So I think it's additional to 25 that. So we've had a lot of clients push back and

1 say, you know, I've been licensed for 15, 20 years. 2 Why all of a sudden are we having to do this? You 3 know, so it's been a lot of push back on the middle 4 people. Trying to figure out why all of a sudden 5 this is an issue and why it's being asked for. GIOVANNA MANNING: And I think, what I -- to 6 7 what I understand, it's being asked for, for when the patient is through. Like, before they leave the 8 9 facility. Not while they're there, to my 10 understanding. 11 CHANTEL CORBETT: It's not for the patient. 12 It's for the public. Being protected from the 13 radiation from --14 GIOVANNA MANNING: From the patient. Right. 15 Okay. Because they're asking 16 CHANTEL CORBETT: Yeah. 17 for, like, the nearest area on the other side of the 18 wall kind of thing. Like where did that --19 ADAM WEAVER: When they're in the choir room or 20 waiting room after they've been injected. Where they wait for 30 minutes to 60 minutes. 21 22 GIOVANNA MANNING: After they've been injected. 23 They want to know, do you guys release them out into 24 the public, you know, or what do you guys do. 25 CHANTEL CORBETT: Yeah. See, that question has

1 not been asked.

2 GIOVANNA MANNING: So that's the issue. 3 CHANTEL CORBETT: I can clarify that with them, 4 too. 5 GIOVANNA MANNING: That's the major -- to what I understand. 6 ADAM WEAVER: Part of the protocol is to keep 7 them quiet. 8 9 CHANTEL CORBETT: Yeah. 10 ADAM WEAVER: Especially if they're imaging the 11 brain. 12 CHANTEL CORBETT: Yeah. I mean typical is a 13 minimum of 45 at the lowest end. You know, up from 14 that. 15 ADAM WEAVER: You don't even let them watch 16 Τ.V. 17 CHANTEL CORBETT: Right. Yeah. MARK SEDDON: Who's reviewing that information? 18 19 I quess there's --20 CHANTEL CORBETT: Well, there's no requirement 21 of who provides that information either, so --22 MARK SEDDON: Right. 23 CHANTEL CORBETT: It's the reviewers. The 24 licensee reviewers. 25 MARK SEDDON: What are they using as the

1 criteria? Just a member of the public? 2 CINDY BECKER: Public criteria release. 3 The release, yeah. Like I GIOVANNA MANNING: 4 said, to my understanding, how I gathered it, it was 5 what do you do with your patient? Do you release them into the public or do you have a protocol 6 7 for --That specific question has 8 CHANTEL CORBETT: 9 never been asked. 10 GIOVANNA MANNING: Okay. Like I said, that's 11 what I got. 12 ADAM WEAVER: Yeah. That opens up something 13 altogether --14 CHANTEL CORBETT: Yeah. There's multiple 15 problems this has already opened up --16 GIOVANNA MANNING: Yeah. 17 CHANTEL CORBETT: -- because, you know, just if 18 you say okay, give me a shielding design, there's no 19 quarantee that they ever put that in. Like, it's 20 telling you what should be in the walls to protect 21 the public. But that's a design. 22 GIOVANNA MANNING: That's a design. 23 CHANTEL CORBETT: There's nothing saying that 24 it was actually done. So even on a new facility, 25 if, you know, a physicist calculates that up and

1 it's a lot of work to do and you give that to 2 somebody, but unless there's actually measurements 3 done after the fact, there's no proof that it's 4 there. And you have a lot people who move into a 5 building --6 ADAM WEAVER: A verification survey. 7 CHANTEL CORBETT: -- that's been used for x-ray 8 or been used for something and they say, oh, yeah, 9 It's already got light in the walls. Go ahead no. 10 and do whatever, you know. So there's just no way 11 to do that without physical measurements. 12 MARK SEDDON: Right. Because the PET 13 facilities generally have a lot of very heavy duty 14 shielding required for uptake rooms. 15 CHANTEL CORBETT: Right. MARK SEDDON: And your design is very dependent 16 17 upon assumptions --18 CHANTEL CORBETT: Locations. 19 MARK SEDDON: -- how you're utilizing the rooms 20 and how many applications you're putting into the 21 I mean, you have three uptake rooms, you may rooms. 22 assume in your design that you're going to have them 23 equally disbursed, but as you know from a lot of 24 permits, this is our favorite room --25 CHANTEL CORBETT: It's closest to whatever,

1 yeah, exactly.

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

8 CHANTEL CORBETT: And rooms change, you know. 9 Like the initial design says on the other side of 10 this wall, it's a supply closet. Well, a year 11 later, they decide oh, that's the best place for a 12 reading room and the doctors are going to sit there 13 all day. So --

14 REBECCA McFADDEN: It's an office.

15 GEORGE GILBRIDE: Oh, that's okay.

16 CHANTEL CORBETT: I know. I mean, if their 17 badge -- if you badge the room, I mean, and test 18 things, yes, but you know what I mean?

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

25 ADAM WEAVER: They want the MOP to be updated

1 every year, so --

2 CHANTEL CORBETT: Right. And we've done the 3 MOP and the MOP goes in with the paperwork on the 4 renewal every time, so, yeah. So that's, that's --5 it's still up, kind of in a fluid state at this point. But just FYI, I mean, I thought it was going 6 7 only on new licenses going forward. But then it 8 came out --9 GIOVANNA MANNING: It's going back. 10 CHANTEL CORBETT: It's on every routine --11 GIOVANNA MANNING: Renewals. 12 CHANTEL CORBETT: -- renewals. They're holding 13 renewals if it's not done properly. So then we're 14 having to get extension letters, which pharmacies 15 don't really care for. 16 ADAM WEAVER: They don't like that. 17 CHANTEL CORBETT: They are supposed to accept 18 them, but you know, they give us a hard time on 19 those too. So, you know, that's --20 REBECCA McFADDEN: And so this is all part of 21 when you're doing the licensure for an actual lab? 22 CHANTEL CORBETT: Correct, but only for PET so 23 far. 24 REBECCA McFADDEN: Only for those facilities performing the PET? 25

1 CHANTEL CORBETT: Yeah. 2 GIOVANNA MANNING: That's what I noticed. 3 REBECCA McFADDEN: So not all. 4 GIOVANNA MANNING: No, not all. 5 CHANTEL CORBETT: I mean, if it's a truly a member of the public thing, it should be for all 6 7 licenses, not just PET. REBECCA McFADDEN: Well, what's the difference 8 9 between the --10 CHANTEL CORBETT: Higher energy. 11 REBECCA McFADDEN: It's the higher energy? 12 ADAM WEAVER: Much higher energy. 13 REBECCA McFADDEN: You answered my question. 14 Thank you. The nonnuclear tech over here asked that 15 question. 16 Heavily shielded rooms. ADAM WEAVER: 17 CHANTEL CORBETT: No, no. Like I said, I asked 18 for the regulation. 19 REBECCA McFADDEN: It's the F -- what's the --20 CHANTEL CORBETT: F18 for the most part, yeah. 21 REBECCA MCFADDEN: Gotcha. 22 CHANTEL CORBETT: But, yeah, that's why I asked 23 for the regulation because I thought maybe it was 24 something that changed that I missed. No, it was 25 just the generic protection of the public from

1 radiation.

2 Then the other catch is, you know, shielding 3 design doesn't allow you to take away background. 4 So if we do a measurement on an MOP with the 5 background, it still says you're getting this but that dose would be -- you would be getting it even 6 7 if there was no nuclear facility there. So, you know, do you take -- can you take that away when you 8 9 do your surveys and say, look, there's nothing 10 additional besides environmental? You know, so you 11 know, that's another question, too.

12 GEORGE GILBRIDE: So is the concern that once 13 the patient is finished with the procedure and 14 they're out in the public, is that what the concern 15 is?

16 GIOVANNA MANNING: That was my understanding.
17 CHANTEL CORBETT: But that's not what's been
18 passed.

19 GIOVANNA MANNING: But that's not what's been 20 happening. That was my understanding. And that's 21 how I gathered it, so --

22 CHANTEL CORBETT: Yeah.

23 MARK SEDDON: That's the release criteria like 24 for iodine patients. Early release. That's a whole 25 different thing.

1 CHANTEL CORBETT: Correct. 2 MARK SEDDON: This is design --3 CHANTEL CORBETT: Even with iodine patients, 4 now with an early release criteria --5 GEORGE GILBRIDE: I'm even thinking about 6 therapy when you treat them with the --7 REBECCA McFADDEN: So they want to know what you're doing with these hot patients. 8 9 CHANTEL CORBETT: Yeah, but see, that's my 10 problem, like, that's her understanding, but that's 11 not what's been relayed to us. So that's the 12 question. Because we've had to literally submit 13 drawings of the facility and what the surveys are on 14 the other side of the rooms in the next -- like, for 15 instance, my one client has a Chinese restaurant next door that borders that wall. So literally, 16 17 thank goodness, the tech has worked there forever and knows the owners of the Chinese restaurant. 18 So 19 he says, can I come over and bring a survey meter into your kitchen, you know. And they're like, 20 21 okay. Okay. I guess if you want. You know, 22 whatever. So I mean, it was background. 23 But, you know, it's just one of those things 24 that a lot of these tenants -- like, hospitals, it's 25 not a big deal. They own the whole building. But

1 when you get into the multi-mixed tenant buildings, 2 it's going to be hard to do that because some people 3 are not going to let you get in to get measurements 4 and they're not going to be as understanding.

5 REBECCA McFADDEN: What about the mobile PETS 6 that show up once a week in some of these practices, 7 too?

8 GEORGE GILBRIDE: That was what I was just 9 going to ask about.

10 CHANTEL CORBETT: Yeah, mobiles are whole 11 another animal.

12 GEORGE GILBRIDE: Whole 'nother breed. 13 ADAM WEAVER: And they're supposed to do 14 surveys before they start.

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

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

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

22 CINDY BECKER: So Chantel, you said your

23 clients have been conversing with different

24 evaluators --

25 CHANTEL CORBETT: Yeah.

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CINDY BECKER: -- and getting their feedback?
 CHANTEL CORBETT: Yeah, we've got Kevin and Joy
 and Rowena.

4 CINDY BECKER: Okay. So our group needs to get 5 together and at least help you guys come up with 6 some kind of consistent plan in what we're actually 7 looking for.

8 CHANTEL CORBETT: Yeah. I mean, I don't think 9 anybody minds doing it.

10 CINDY BECKER: Right.

11 CHANTEL CORBETT: It's just I don't want, you 12 know, all the different groups having to submit 13 different things, and if it's as simple as doing 14 some surveys --

15 CINDY BECKER: Right.

16 CHANTEL CORBETT: -- that's wonderful. If 17 you're saying we're going to have to go back and do 18 shielding integrities or all these crazy

19 measurements that takes hours of time, then that's a 20 whole another animal.

21 ADAM WEAVER: You just want the consistency 22 between --

23 CHANTEL CORBETT: Yeah. Right.

24 CINDY BECKER: The consistency and one of the 25 things, you know, we are regulated by the Nuclear

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

5 CHANTEL CORBETT: I figured this is what 6 triggered it.

7 CINDY BECKER: I think is what triggered it and 8 so I think Giovanna, we'll take it back and we'll 9 get together with the group, because I -- they're 10 coming back in June to do a mid, kind of oversight 11 look at us. They'll do the full-blown audit 12 probably next May or June, 2023 -- 2022.

13 CHANTEL CORBETT: I mean, I guess the other 14 question that came up was that they are very 15 assumptive that the x-ray section is getting the 16 shielding design submitted for every time a CT gets 17 put in and I don't think that's the case, either. 18 Yeah.

19 ADAM WEAVER: No.

20 CHANTEL CORBETT: So I was like, to my 21 knowledge, no. But I am glad I see agreement 22 because I didn't think that that was the case, 23 either. That was kind of what prompted -- they've 24 always been taking care of the CT side of the 25 shielding, but we now need to take care of the PET

1 side. So I think there's some miscommunication on 2 that as well. 3 CINDY BECKER: Right. Right. Well, thanks for 4 bringing that up because --5 CHANTEL CORBETT: No problem. REBECCA McFADDEN: She always has good stuff to 6 7 bring to the table. Give her six months and you've 8 got something good. 9 CHANTEL CORBETT: If you have the fun clients I 10 do. 11 REBECCA McFADDEN: You do. You have good stuff 12 that comes up. CLARK ELDREDGE: I think some of that is from 13 14 accelerators and making the products. That's where 15 that's --16 CHANTEL CORBETT: Yeah. 17 CLARK ELDREDGE: -- because we've been getting 18 the shielding reports for the cyclotron system. 19 CHANTEL CORBETT: Yeah. For, like, bulbs and 20 all that kind of stuff, yeah. 21 CLARK ELDREDGE: That's what they required. 22 CHANTEL CORBETT: If everything was three feet 23 of concrete, we'd be all good across the board. ADAM WEAVER: It doesn't work well in the 24 25 ceilings.

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

3 GIOVANNA MANNING: Okay. 4 DR. RANDY SCHENKMAN: So is that --5 GIOVANNA MANNING: That's it. Okay. Anybody have 6 DR. RANDY SCHENKMAN: 7 anything else to add? 8 JAMES FUTCH: Who can top that? Come on. 9 REBECCA McFADDEN: No one. Chantel, hands 10 down. 11 CHANTEL CORBETT: Sorry. 12 DR. RANDY SCHENKMAN: Okay. So now we're going 13 to go on to our Superficial Radiation Therapy for 14 Dermatological Care. 15 DR. LIO YU: Before we do that, I'm going to switch chairs. This chair is a little tilted. 16 17 CLARK ELDREDGE: I do have a little history 18 here. So in the course, the Council here had a 19 presentation or discussions, I should say, in 2013 20 and 2014. And in 2013, Dr. Williams had brought a concern up to Council on exactly what's -- what the 21 22 training is, what's the knowledge base for the use 23 of SRT therapy machines.

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

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

6 There was a little follow up in September of 7 2014, but it was briefly mentioned in the meeting 8 notes and nobody, you know, did the true follow up. 9 So this is part of that to follow this up.

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

While the bylaws of the American Board of 16 17 Dermatology do say that they have set requirements 18 for, educational training requirements for 19 dermatologists, radiation physicists and radiation 20 therapy, nothing else on their site mentions When you search for the word radiation 21 radiation. 22 on their site, other than in their bylaws. And when 23 you look up their standards for oncology, et cetera, 24 that type of stuff, it all talks about surgery, Mohs 25 and things like that.

1 There is a document out there that is actually published in the Journal of Clinical Anesthesiology, 2 3 Dermatology, Aesthetic Dermatology, if I can get it 4 out right. That is actually also posted on Sensus' 5 website. Then it talks about not necessarily the qualifications and whatnot of the individual, the 6 7 dermatologists themselves, what they should know ahead of time. But what's -- what type of treatment 8 9 you should be giving and what course of treatment 10 and things like that. That's that focus.

11 So there's several things that talked about out 12 there I was able to find that talked about clinical 13 practice, but nothing about who should be doing it, 14 how they should do it, what their backgrounds should 15 be; that type of thing, which if you look at our other radiological, our therapy posts, there's 16 17 generally -- there's something about who's behind 18 the button.

19 The CRCPD, CRCPD, has no -- in their state --20 suggested state regs, really makes no 21 differentiation on any type of radiation therapy, 22 the use of radiation oncology, radiation type of 23 stuff, you should have a gamut of therapists, 24 oncologists, medical physicists and the team working 25 on this.

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

6 So looking this up, trying to find more 7 background for you all, whatever, you know. So 8 that's why it's important these folks are here today 9 to help us see -- explain what they are seeing in 10 their world.

11 So I appreciate you all coming today to talk to 12 us on this. Anything else I wanted to point --13 currently, we do have on our registration, eight 14 Grenz Ray machines, one ultra voltage, 75 SRTs, 15 looking for use code rather than model name in our And the SRTs are currently all Sensus 16 databases. 17 and Xoft has also contacted the Department with 18 plans to market their EB IORT in an SRT mode because 19 they've got an add-on kit that converts it to an SRT 20 usage rather than electronic brachytherapy or 21 intraoperative radiation therapy. So -- anyway, 22 that's my --

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

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

And then let me make introductions. 8 So this is 9 Dr. Lio Yu. He's a radiation oncologist that works 10 with SkinCure Oncology and our practice partners. 11 He's also the author or co-author of the largest 12 superficial radiotherapy study, clinical evidence 13 based study that's ever been, you know, achieved. 14 And that, that is from the place of service 15 dermatology with authorized users; dermatologists.

16 This is Steven Scott. Steven is our chief 17 operating officer of SkinCure Oncology. He also is 18 a Board certified radiation therapist with a long 19 history within free standing and hospital-based 20 radiation facilities.

21 So my name is Joshua Swindle, Board certified 22 radiation therapist. I oversee the practice 23 operation side for SkinCure Oncology. I really give 24 a lot of the leadership and support to our practices 25 and to our clinicians that are utilizing superficial

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1 radio therapy.

2 So Steven, anything you wanted to add? 3 STEVEN SCOTT: Yeah. Again, we appreciate you 4 guys inviting us to be here today and ordering up 5 this amazing weather. This is just fantastic. We 6 appreciate it.

7 You know, one of the main reasons that we decided to form SkinCure Oncology back in 2016 was 8 9 because we knew there were a lot of dermatologists 10 wanting to do this. And if you went out there and 11 looked at 100 different practices, you would 12 literally see 100 ways of doing things. So coming 13 from a hospital-based radiation oncology background, 14 what we wanted to do was create an environment that 15 was all about patient safety, right?

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

22 So, you know, there's no shortage of skin 23 cancer, right? Over 5 million new diagnoses every 24 single year. You guys, a big chunk of that is in 25 Florida, by the way.

1 (Laughter).

2 STEVEN SCOTT: Yeah.

3 REBECCA McFADDEN: It's the weather.

4 STEVEN SCOTT: And because of our background, 5 because of the folks that we knew, that's when we decided to make all this happen. And so he's going 6 7 to get into a lot of the nuts and bolts of what makes the program work. And Dr. Yu can talk a 8 9 little bit about the protocols that have now been 10 established and our, essentially, the nationwide 11 protocols being used specifically in image guided 12 SRT or IG-SRT.

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

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

1 it's obviously really important that they get proper 2 training. So the manufacturer does training for 3 them and then we do training for them over and above 4 that with regard to appropriateness of use and, you 5 know, what patient is a good patient and what patient is not a good patient for radiation. 6 Making 7 sure that they understand all of that. How that's all going to work. And Dr. Yu oversees our grand 8 9 rounds that happen on a weekly basis nationwide for 10 how they discuss more complex cases or something 11 that might be a little bit unusual.

12 So, you know, if you take anything away from my 13 part, which I promise I'll shut up because I know we 14 have a schedule to be on here. It is that this was 15 established, first and foremost, for patient safety. Okay? We have very, very comprehensive radiation 16 17 protection programs. We certainly understand the 18 spirit and intent of CRCPD Part X, which basically 19 everyone has adopted, and what needs to happen so 20 that everybody feels confident that somebody has not 21 just gone off the reservation and is doing something 22 out there maybe possibly hurting a patient, or 23 operating in an unsafe way, where we have mechanisms 24 that, you know, use record and verify systems, use 25 medical physicists, have radiation oncologist

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1 oversight, again, weekly grand rounds. Looking at 2 everything and anything that needs to be addressed 3 so that when you guys do provide authorization for 4 an authorized user and grant that registration, 5 hopefully you guys feel very comfortable on what has been submitted to you on behalf of that practice. 6 7 Knowing they have initial training and as much ongoing training as they would like some of the 8 9 states out there do require the authorized users, 10 dermatologists in this case, to have annual 11 retraining again. And that's something we provide 12 to any of our practice partners who want this.

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

17 Again, we have medical physicists on board as 18 well. We have two full time; we have two part time 19 and then we have a handful that are contractors so 20 that we have some overlap and some continuity of 21 care just in case something has to be done. Every 22 chart gets checked every fifth fraction. Everv 23 patient's calculations get checked by a third 24 fraction. You know, just exactly like you would see 25 in a cancer center and making certain, again, that

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1 these dermatologists are really well versed. Thev really know what they're doing and, in fact, from 2 3 our perspective, if we see a dermatologist operating 4 in an unsafe fashion, obviously we would bring that 5 to their attention. And if they, if they won't change their ways, if you will, we divorce ourselves 6 7 We won't be associated with the practice from them. that's not going to do it right. 8

9 We're also really, really stringent on 10 reporting of any misadministrations, right? And 11 some of the states have actually been quite 12 surprised when we know there was a misadministration 13 and we made certain it was reported and a corrective 14 action plan was put into place. I'm very happy to 15 say, over those 35,000 patients that have been treated, there's only been five or six 16 17 misadministrations in the entire country, but all of 18 those were followed up accordingly; additional 19 safety procedures were put into place to make certain that, you know, hopefully that never 20 21 happened again.

22 But that's a real high-level overview of how we 23 came up with the thought process for developing 24 SkinCure Oncology and with that, I'm going to turn 25 it back over to Josh. Go ahead and roll through the

1 PowerPoint.

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

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

10 As far as our mission goes, it's "to empower 11 patients and dermatology practices by providing the 12 highest level of education and expertise needed to 13 deliver superior outcomes for non-melanoma skin 14 cancer." I think that really aligns with the 15 Florida Department of Health's mission, which is to protect, promote and improve the health of all 16 17 people in Florida through integrated state, county 18 and community efforts. So our missions are very 19 much aligned. It's having accessibility to patients 20 and making sure that it's done in a safe manner.

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

within the dermatology space under the supervision
 of a dermatologist.

3 So part of that program, obviously, is 4 radiation safety officers. Radiation facility 5 protocols. Utilization of a Board certified radiation therapist. In this case, also state 6 7 licensed within the State of Florida. To beam on under the supervision of the physician. 8 Medical 9 physicists, as Steven mentioned, that's just not for 10 initial and ongoing calibrations, but we use our 11 medical physics team for quality assurance on the 12 technology throughout, you know, operations as well 13 as quality assurance on the patient prescriptions.

14 And then access to radiation oncologists. We 15 have Dr. Lio Yu. He works very close with our chief medical officer that is a Mohs surgeon out of Texas. 16 17 They are constantly reviewing outcomes; they are 18 constantly reviewing protocols. They provide a 19 weekly grand round that is hosted by them; that is 20 accessible to all of our practice partners; mandatory for all of our radiation therapists to 21 22 attend.

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

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

3 So, Dr. Yu, do you want to speak on some of the 4 interesting cases that have come across at grand 5 rounds and why that's beneficial to our practices?

DR. LIO YU: Yeah. Sure. So first of all, 6 7 thanks for inviting us. And just to give you a little background, I've been a radiation oncologist 8 9 for almost 30 years, so I've treated all kind of 10 A lot of cancer cases. Mostly really cases. 11 advanced cases. Because the dermatologists always 12 send the train wrecks to the radiation oncologists. 13 The other ones, everybody gets cut. The early stage 14 cancer patients, they get cut and I feel that's 15 unnecessary surgery.

So for about twenty plus years, I've been 16 17 trying to convince the dermatologists that radiation 18 works really well. There's no scar. So I was 19 really thrilled when SkinCure Oncology had this 20 endeavor and I saw the model was excellent. Thev 21 take the cancer center model and applied it to the 22 dermatology world.

23 So we got to -- part of my responsibilities, 24 besides doing -- helping them with some research, 25 which is education, weekly grand rounds that we run.

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1 We have the therapists from the different practices present difficult cases. And, and these cases are 2 3 important because sometimes, they don't realize that 4 there could be a pitfall. For instance, you have 5 overlapping beams. If you're treating one side of the nose, the other side of the nose, you know, even 6 7 though it may be three months later, it could be a problem with the septum getting the necrosis because 8 9 you're getting maybe double the dose or, you know, 10 extra dose that you shouldn't be. Or contour 11 Sometimes they have the nose going differences. 12 into the cone and it goes in several centimeters, 13 and they don't realize, oh, the tip of the nose is 14 actually getting 200 percent of the doses.

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

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

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1 And satisfaction, you know, patient satisfaction is, is really critical. And that's 2 exceeding 99 percent. Patients love having this 3 option. It is new; it is innovative. 4 There's a 5 huge adoption right now within the dermatology space because there's a big need. You know, 5.4 million 6 7 cases diagnosed on an annual basis that, you know, requires treatment. And the majority of those 8 9 patients have been receiving surgery as their sole 10 treatment or if they don't want to have surgery or 11 they've come too late in the game, they're having 12 such an advanced case that they're requiring a mega 13 voltage style radiation treatment and possibly even 14 systemic treatment.

15 So when I was speaking with Clark about where we could, you know, come in and help -- and we love 16 17 to be an industry expert and, you know, give any 18 sort of guidance that we can to the State of 19 Florida -- I look at this as far as risk versus 20 benefit. You know, what are the risks of this being within the dermatology practices? And the risks 21 22 right now, from what I can perceive on some 23 practices that we, we have come across is, you know, radiation protection programs. 24 What do the 25 inspections look like from the Department of Health?

1 What do the radiation protection programs look like 2 for their ongoing operations? We always say that 3 the radiation protection program binder is really 4 kind of the Bible of the program. And it's a good 5 look into what the practices are really doing on an 6 annual basis.

7 Quality assurances. You know, what quality assurances are in place to make sure that the safety 8 9 and efficacy is there? Who are your authorized 10 users? Are we using appropriate clinicians for the 11 delivery? Are we using appropriate clinicians as 12 the authorized users? What is the training and 13 then, the biggest risk is that we button the 14 regulatory up too tight to where it's inaccessible 15 to people of Florida. Obviously, Florida has a large need for this particular cancer. 16

17 So benefits of it being in the dermatology 18 setting is the incidence. There's a large incidence 19 of these skin cancers that require a non-surgical 20 solution. It's a place of service that it's 21 diagnosed. If it's not accessible within that place 22 of service, more than likely, the patients are going 23 to have one option and that's surgery.

24There needs to be a safe and non-surgical25solution there. So with the appropriate model, you

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

3 So the technology and training and safety, this 4 is, you know, the particular superficial unit that 5 SkinCure Oncology utilizes. There are other manufacturers out there. Sensus Health Care has a 6 7 couple of different types of technologies. This third-generation technology really provides the 8 9 highest level of care and safety measures from our 10 perspective.

11 So this is the SRT-100 Vision unit that is 12 manufactured by Sensus Health Care. And as far as 13 the unit goes, this particular unit does have an 14 onboard dosimetry program. It has a cloud-based 15 electronic health record that allows our medical physics team to do reviews on those prescriptions 16 17 that are in place. It allows them to do reviews on 18 the daily checks that the radiation machine goes through on, on, you know, for quality assurance and 19 20 quality checks. And then it has record and verify, just like you would find at a health center 21 22 environment. It has a verification that what was 23 delivered yesterday is being delivered today. So 24 again, multiple safety measures in there.

25 The therapist does a warm up on the technology

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

So, and then the training. What training is 6 being completed? Steven had talked about the 7 manufacturers providing training to the 8 9 dermatologists prior to, you know, being able to 10 utilize the technology. And then we really take it 11 a step further and do an extensive clinical training 12 with, you know, the subjects of radiation safety, 13 physics, the manufacturer's training I mentioned, 14 clinical applications, user training and really best 15 practices. So those are the training environments that we, we, you know, spend the most time in. 16

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

23 So as far as assurances on the safety and 24 efficacy, really, our radiation protection binders 25 and our programs that -- there's a monthly

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

4 So the clinicians that we, we believe are most 5 appropriate would be a Board certified radiation therapist licensed within the State of Florida to 6 7 deliver the treatment under the supervision of a physician and/or a physician to deliver the 8 9 treatment. Those are the two individuals that we 10 find to be the most appropriate. And then having 11 that medical physics support that we've mentioned 12 several times on the quality side.

13 You know, as far as physics goes within the, 14 you know, superficial realm, superficial is still 15 delivering therapeutic doses of radiation. It's very high doses of radiation and there is, you know, 16 17 potential danger and having that medical physicist 18 as a safeguard and doing those spot checks, spot 19 checks are critical. That's what allows us to catch things before things could occur in the 20 21 misadministration.

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

1 in place to make sure that these things are reviewed 2 quite frequently so that when the Florida Department 3 of Health walks in, it does an inspection, the 4 inspection goes extremely smooth and easy and we 5 know that our patients are being treated 6 appropriately. 7 JOSEPH DANEK: I've got a question for you. JOSHUA SWINDLE: Yes, sir. 8 9 JOSEPH DANEK: I noticed you had film badge 10 reports on there. Do you use film badge rather than TLD, 11 thermoluminescent dosimeters or OSL? Is the film badge 12 the method used for personnel monitoring? Why film badge? 13 CHANTEL CORBETT: No. It's probably GSLDE. 14 It's just a generic. 15 ADAM WEAVER: I think it's just radiation 16 dosimetry. 17 STEVEN SCOTT: It's just personnel monitoring. 18 CHANTEL CORBETT: Yeah. 19 JOSEPH DANEK: Well, it's personnel monitoring, 20 but it's probably not film badge. 21 CHANTEL CORBETT: It's not true film anymore. 22 STEVEN SCOTT: No. 23 JOSEPH DANEK: Yeah, right. 24 STEVEN SCOTT: So if -- there are a couple 25 states that actually require us to do an annual TLD

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

JOSEPH DANEK: Okay.

4

5 STEVEN SCOTT: We actually are kicking around 6 now, moving to the new electronic personnel 7 dosimeters. It's just a hell of a lot cheaper, but 8 that probably will be something we move into next 9 year.

10 JOSEPH DANEK: Okay. Thank you.

11 WILLIAM ATHERTON: Also a Question on the 12 shielding, so these are going -- you're trying to 13 put them in dermatologists' offices. How is -- does 14 it -- is it designated in one room and then how, how 15 do you do the shielding for that room? Is it 16 usually extensive?

17 ADAM WEAVER: Does it require shielding? JOSHUA SWINDLE: It does require shielding. 18 19 So, yes, it is done within, you know, a 20 free-standing physician office. Typically, the, you 21 know, size of the room is ten by ten or an exam 22 The shielding is created by our medical room. 23 So our medical physicist will look at physics team. 24 the output of the technology, the expected run time, utilization of it, and they will create a shielding 25

1

report that then is submitted to the State.

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

7 WILLIAM ATHERTON: Physically alter the room. JOSHUA SWINDLE: They create a little micro 8 9 vault. So it is lead-lined gypsum board, though. 10 And then medical physics, upon that initial 11 calibration, would come in and do any sort of area 12 surveys and, and make sure that there's no leaking. 13 DR. NICHOLAS PLAXTON: Is it gamma radiation? 14 ADAM WEAVER: X-rays. 15 It's X-rays. Electronic, yeah. JOSHUA SWINDLE: WILLIAM ATHERTON: Are there any safeguards --16 17 DR. NICHOLAS PLAXTON: Scanner. Same thing.

18 ADAM WEAVER: Photon.

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

23 room. Within our practice partners, there are some 24 practices that might move their machines from

25 facility to facility. We, you know, we think that

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

4 It is mobile within the room. So you have some 5 wiggle room to move it.

6 ADAM WEAVER: So you can stick it in a corner 7 when you're not using it?

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

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

17 JOSHUA SWINDLE: I would, I would say probably 18 not.

19 MARK SEDDON: Right.

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

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

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

8 MARK SEDDON: So for, for Clark, you asked him, 9 so for the other -- not these guys, but other 10 facilities that use SRT in Florida, do you, do they 11 submit the shielding designs to you folks?

12 CLARK ELDREDGE: They have to use surveys. 13 Well, our codes cover -- we have above -- we have a 14 code for over MeV, under MeV and brachy, right? So 15 under MeV, we require surveys. Post whatever -- we don't require pre-submission of pre-designed plans. 16 17 We do require pre-designed plans in the MeV and 18 above facilities for therapy. So -- but they do 19 have to have -- they have to do a post build-out 20 survey, showing that they're going to --21 calculations to show they're going to keep public doses down, et cetera. 22

23 MARK SEDDON: Right.

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

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

5 ADAM WEAVER: Does it vary the energies during 6 treatment or are you looking for the different 7 depths?

3 JOSHUA SWINDLE: It can vary. So one of the 9 benefits of having the image guidance component, 10 which is an ultrasound-based imaging, is you can 11 provide an adaptive radiotherapy approach. So if 12 you see a significant change in the lesion depth or, 13 you know, need for an adjustment in the energy, that 14 can be done in realtime.

15 MARK SEDDON: And is that decision made by the 16 therapist?

JOSHUA SWINDLE: By the authorized userphysician.

19 MARK SEDDON: The physician.

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

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1 to adjust our protocol to X.

2 MARK SEDDON: Okay. But you wouldn't have --3 you don't have direct physicists to change plans. 4 It would just be --

5 JOSHUA SWINDLE: There's direct access to the 6 physicists, but the authorized user is the 7 prescribing, you know, physician in this case. 8 MARK SEDDON: Right.

9 REBECCA McFADDEN: Do the dermatologists get 10 additional certifications from a dermatology

11 standpoint?

JOSHUA SWINDLE: Say that one more time. REBECCA McFADDEN: If the dermatologist is the one who's prescribing and you're saying that he's an authorized user, does -- would he require additional certifications in order to do that from a

17 dermatology standpoint?

18 STEVEN SCOTT: NO, not additional

19 certification, no. No. As physicians are the

20 healing arts, you know, they do get some of this

21 exposure in school. Some of the older docs that are

22 out there, the old-school guys, they know a hell of

a lot about this.

24 REBECCA McFADDEN: Right.

25 STEVEN SCOTT: The younger guys, not so much,

1 right? But what you're seeing is a lot of the 2 younger guys coming out of school now wanting this 3 because they've seen how great the outcomes are and 4 now with the third-generation technology, a lot of 5 them are wanting to adopt it.

6 But, you know, to your point, what we don't do 7 is, we don't just say, well, you've had the 8 manufacturer's training. You've been deemed an 9 authorized user by the State. Good luck. No. 10 There's quite a bit of work that goes in to make 11 certain that they understand what is clinically 12 appropriate and what is not.

13 MARK SEDDON: The gap, right, would be the 14 clinical radiation oncology, radiation biology piece 15 is that most of them do not have and the training.

JOSHUA SWINDLE: And we have the luxury of 16 17 having the support from, you know, kind of that 18 mile-high view that anything that is not, you know, 19 within a pretty little box, that that can be 20 submitted and peer reviewed by multiple physicians. We do have, you know, Dr. Yu. We also have another 21 22 radiation oncologist that works with us and we have 23 several dermatologists that have been doing this for 24 a long period of time.

25 REBECCA McFADDEN: Right.

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1 STEVEN SCOTT: And sometimes we do involve the 2 medical physicists depending on what the set up 3 might look like. It might be an unusual set up we 4 need some help with. You know, maybe because of the 5 obliquity of the beam or, you know, because the lesion is changing so much in realtime. 6 You know, 7 back to your point. This is not like treating a lung or, you know, prostate or something. I mean, 8 9 you see significant changes, guite literally, on a 10 daily basis.

The other thing, too, is because the technology 11 12 does have the ultrasound capability, it also has a 13 Doppler feature, which is pretty amazing because, 14 yes, we want to make necessary adjustments to the 15 lesion as a doctor prescribed, but by the same token, you also want to look at that subdermal layer 16 17 and see what's going on from a vascularity and 18 repopulation perspective. Unfortunately, the 19 practices that don't have image guidance have to 20 make a call. I'm going to use 50, I'm going to use 70, I'm going to use a hundred. Why? Well, because 21 that's what I'm comfortable with. 22

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

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

8 And then there's also the consideration of the 9 normal granularization of tissue down below all of 10 that because you don't want to just destroy that 11 tissue in the process. It really is the best of all 12 worlds.

13 WILLIAM ATHERTON: I have a question just on 14 the selection of lesions; how that works. Like are 15 these, does it have to be, like, a biopsy-proven 16 cancer before they use this?

17 STEVEN SCOTT: Yes.

18 WILLIAM ATHERTON: It's not like, that's a19 suspicious mole, let's use this.

20 STEVEN SCOTT: No, it doesn't work like that, 21 no. Very, very rarely would you have a case that 22 needed to be treated without a biopsy. It would be 23 just like you would see in a cancer center. Every 24 once in a while that does happen, right?

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

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

The only one that falls outside really are 6 7 keloids, right? The radiation is incredibly effective for keloids. I'm an old-school radiation 8 9 therapist since the 80s. I've treated, I don't know 10 how many keloids. I've never had one come back. 11 And so, you know, if any of guys have ever have a 12 family member or yourselves having ever dealt with a 13 keloid, it's awful. It's painful. It itches. It 14 causes adhesions. And so a lot of the practices are 15 utilizing radiation now rather than just injecting it with Kenalog -- which we all know doesn't work --16 17 and getting amazing results in controlling those 18 things. It just takes three fractions, about 18 19 grade, to knock them out.

20 DR. NICHOLAS PLAXTON: I just have an overall 21 question. It sounds like the patient has to come 22 for multiple visits, right? Like, what's the 23 typical treatment? Like, how many sessions do they 24 have to come to? Because it seems a lot more 25 complicated than just cutting it out and throwing

1 it --

5

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

DR. NICHOLAS PLAXTON: Right.

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

10 So as far as the treatments, they're, you know, 11 typically delivered three to four times per week. 12 The sessions are anywhere from, you know, ten to 13 fifteen minutes depending on the quantity of lesions 14 or the complexity of the set up. But the patients 15 are able to walk right in; walk right out. And, you know, three to four treatments per week over five to 16 17 six-and-a-half weeks.

DR. NICHOLAS PLAXTON: So it's a timecommitment then.

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

23 DR. NICHOLAS PLAXTON: Sure.

24JOSHUA SWINDLE: Luckily, what are they going25to do spending their time? They actually enjoy

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

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

10 JOSHUA SWINDLE: As far as cost difference of 11 the, like --

DR. NICHOLAS PLAXTON: Yeah, radiation
versus --

14 JOSHUA SWINDLE: -- what the reimbursement 15 would be? Honestly, they're within the same playing You know, when you really look at apples to 16 field. 17 apples, you know, of surgeries that might require 18 reconstructive surgery, you know, any sort of 19 plastic involvement, any sort of, you know, poor outcome from a surgical, you know, failed wounds, 20 21 and then you look at what little toxicity and little 22 complications there are with this particular device 23 and appropriate protocols and the quantity of 24 lesions that are treated at a time.

25 You know, the average lesion per patient is 1.7

1 lesions. And so, with radiation, we typically 2 treat, you know, up to three lesions at a time; 3 whereas surgery is done one at a time. So if you 4 look at a true cost comparison, they're really 5 within the same playing field. CHANTEL CORBETT: And most insurance companies 6 7 are open to either option? Or --8 JOSHUA SWINDLE: Sure. Yes. Most, most payers 9 are, you know -- I mean, the payers are payers. Ι 10 won't put anything on the record about payers, 11 but --12 Right. Well, I know CHANTEL CORBETT: 13 sometimes they really try to steer towards --14 JOSHUA SWINDLE: They do. 15 CHANTEL CORBETT: -- one or the other. JOSHUA SWINDLE: The least expensive option 16 17 they can for patients. But, yes, most payers, both 18 federal and commercial, are reimbursing for, you 19 know, this particular service line. 20 STEVEN SCOTT: Yeah, but most of them now are following the NCCN guidelines which have been 21 22 recently updated and radiation is a first-line 23 therapy now for non-melanoma skin cancer. So 24 obviously, we're selfish to what we do, but by the same token, we think every patient ought to have 25

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

3 DR. NICHOLAS PLAXTON: You were talking about 4 the elderly patients. Like, you know, I know, like, 5 surgery tends to -- you have problems with, like, wound healing and whatnot. Like, does this -- has 6 7 there been a study showing this has, like, a better outcome from that? Like, can you get, like, wounds 8 9 that are caused from this radiation that don't do 10 well, I guess, in elderly patients?

11 DR. LIO YU: Well, this -- the protocol that we 12 use is something that's kind of, in the radiation 13 oncology world, a middle-of-the-road type of 14 treatment. If you went to a cancer center, the 15 treatment would actually be much more, much more frequently. Like five days a week and be about six 16 17 and a half, seven weeks. About 30 to 33 treatments. 18 Typically, it would be about 20 treatments, because 19 these are small lesions and they don't need to be 20 treated every day. So it's kind of a middle-of-the-road situation. 21

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

1

of having some ulceration complications.

So in the study that we did about 3,000 cases, 2 the safety is excellent. In fact, only grade one, 3 4 mostly grade one arrhythmia; some hyperpigmentation 5 that occurs on these patients. Very rarely do you have anybody who has even, you know, moist 6 7 desquamation. And I think it was like maybe one or two cases out of the 3,000 that had a grade, like a 8 9 grade three toxicity.

10 STEVEN SCOTT: And we certainly have seen, in 11 some of the practices that we've been brought into, 12 patients that are coming in for follow up that they 13 treated, you know, two years ago before SkinCure 14 Oncology even existed kind of thing, and they were 15 really rushing the fractionation. They were doing it in six fractions, maybe eight. 16 The risk of, of 17 significant breakdown, ulceration, goes up 18 substantially. You start treating in 12 fractions 19 or less, you're going to see something greater than 20 20 percent of all patients end up on brach. And some of those patients, sadly, will end up in 21 22 hyperbaric wound care and have to have constant 23 Those things just don't want to heal debridement. 24 if you get after it really fast.

25 But we also see a lot of complications on the

1 Mohs surgery side. Anything below the knee on an elderly person, you know, is almost impossible to 2 3 Most of these patients are on some sort of a heal. 4 blood thinner. It's -- there's a lot of reasons, 5 good reasons to have radiation if it's done appropriately. You know, and we're actually very, 6 7 very proud of the protocol that we support. It was jointly developed with Dr. Yu's help as well, which 8 9 is what we think is a good balance. And that is, 10 you know, it's really difficult to tell a patient 11 who doesn't believe they're dying, that you've got to come in 33 times, right? If that happens in a 12 13 cancer center, of course, the patient is going to 14 say, yeah, I'm coming in.

15 But to say to a patient, okay. We want you to come in 30 times to your dermatologist's office, 16 17 even though 30 fractions would actually be safer, 18 right? We can all get behind that. It's a 19 difficult ask. And so stopping it at 20 is what the 20 radiation oncologists have felt comfortable with that we can deliver a tumoricidal dose and have 21 22 very, very minimal number of patients that have bad 23 outcomes or end up on brach.

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

1 people. They love to see folks and say hi and stuff like that. 2 They get actually very attached to their 3 radiation therapist and they get to where they enjoy 4 coming in and being seen. And it might be the only opportunity they have in their life to not be 5 sitting in a room naked in a paper gown waiting an 6 7 hour and a half for the doctor to show up. Thev literally drive right in, they come right back, they 8 9 get treated. It's, you know, it's a great quality 10 of life. It doesn't preclude them from doing 11 anything they want to do.

12 What comes to mind is a guitar player that I 13 treated years ago in Austin. He was very worried 14 about losing the use of his hand because that was 15 his livelihood. And so, you know, we did perform radiation on it. He had an amazing outcome. 16 He is 17 still performing live today. So it's not just for 18 people who have stuff on their face. Although we 19 can, I think we can all understand, you know, people 20 don't like scars on their face per se.

21 So a lot of patients do ask for this type of 22 treatment. And, you know, there's only a handful of 23 centers out there right now that are performing 24 IG-SRT. Hopefully that changes in the future and 25 it's available to anybody in any state.

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1 JOSEPH DANEK: What's the typical treatment 2 The range of dose treatment. I know it depends on dose? 3 the cancer. But just typical cumulative total 4 treatment dose applied? 5 STEVEN SCOTT: Between 5 and 6,000 centigrade. JOSEPH DANEK: Between what? 6 7 STEVEN SCOTT: Between 5 and 6,000. Usually it's around 5400 to 5600 is usually the tumoricidal 8 9 dose delivered. Delivered at about 275 centigrade 10 per day, three to four days per week. 11 DR. NICHOLAS PLAXTON: The other question I 12 have is, like, with different modalities, especially 13 like the face, like I mean, I know they use, like, 14 immune therapy creams, right, for -- which 15 essentially is not going to leave a scar, either, and you just apply that for, like, a month or two, 16 17 right? 18 DR. LIO YU: Well, it's not that simple. The 19 new targeted agents for basal cell are called 20 Erivedge and they have also one for squamous cell. 21 The response rate is, the complete response rate is 22 only about 40 percent. So even though they're using 23 that, it's not -- most of the cases, it's going to 24 come back. So even though they're getting it, they 25 still need to have primary treatment, whether it's

1 surgery or radiation therapy.

2 ADAM WEAVER: Follow-up treatment. 3 STEVEN SCOTT: Yes, sir? 4 WILLIAM ATHERTON: Do you see if there's any 5 risk being that they're -- it's a general dermatologist, it's not a radiation dermatologist, 6 7 that there would be any pressure, financial incentive or otherwise, for that dermatologist to --8 9 is there a risk for him to start using it on more 10 and more lesions that maybe, maybe he doesn't 11 know -- maybe just to start overutilizing it? 12 STEVEN SCOTT: Obviously, that's always a 13 concern. You know, there could be overutilization. 14 That's why the clinical use appropriateness is such 15 a big part of the training we provide. That's why I kind of lead into this segment with, you know, if 16 17 you went out there to 100 different practices that are doing this, you'll get 100 different flavors of 18 19 what it looked like. But what I will say is from what I have seen 20 21 for the most part, across all of these 22 dermatologists out there, whether they're, you know,

23 practice partners of SkinCure Oncology or not, is 24 you don't really see people doing it just for the 25 money. Honestly, they, they try to do what's best

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

5 So we think that there should be a balance, and certainly, you know, I mentioned if we had a 6 7 practice that we partner with that was sort of off the reservation, if we saw them sending every single 8 9 patient to just radiation, I mean, that would give 10 us pause, right? Because it really ought to be a 11 solid 50/50 mix. It should be the patient's choice, 12 not the doctor's. They should be presented all 13 options and say, okay. Here's what we can do. We 14 can freeze it with nitrogen and it's going to come 15 I promise you, every single time. Okay? back. We can cut it out and, you know, maybe you have a scar 16 17 and maybe you don't. Maybe you end up with a big 18 flap or some large plastic surgery repair and maybe 19 you don't. And certainly there's are different 20 grades of Mohs surgeons out there. Some are really 21 good; some are not. Or you can have radiation, you 22 know, and here's the information.

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

1 consent of all their options, even if it's not 2 something that that practice provides. They should 3 be able to look that patient in the eye and say, 4 here's what we do here, but there are other 5 alternatives as well. WILLIAM ATHERTON: 6 Thank you. 7 REBECCA McFADDEN: When you get that law 8 passed, do it for everything. Know all options. 9 JOSHUA SWINDLE: It should be done for 10 everything. Full informed consent is, 11 unfortunately, not fully completed. 12 STEVEN SCOTT: Unfortunately, it's not. How we 13 doing on time? We don't want to run them long. 14 DOUGLASS COOKE: We have about ten minutes. 15 STEVEN SCOTT: Dr. Yu, do you want to address what was found in the study? 16 17 DR. LIO YU: Yeah. So basically, the -- it's a 18 multi-institutional study. It's a retrospective 19 study. We looked at about 3,000 cases and about 20 1600 patients. And these are Stage 0, 1 and 2 patients. So early in situ, squamous cell carcinoma 21 22 in situ lesions with full thickness atypia, which is 23 defined by NCCN as something that's suspicious. Not 24 just a very small, superficial lesion. Up to four centimeters in size. Stage T2. 25

1 These lesions are treated pretty much uniformly, about 20 fractions. They were given 2 3 three or four times per week and we analyzed the 4 results. So the control rate was excellent. About 5 99 percent. 99.3 percent to be exact. And we, we broke it down in the paper of different histologies 6 7 and we also looked at the safety in terms of RTOG toxicity. So it was overwhelmingly safe and it's 8 9 overwhelmingly effective.

10 So this kind of is the proof in the pudding 11 that is protocol and this method, which I knew from 12 years ago that this, this technology is fantastic 13 and it's great for patients to have as an option.

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

20 dermatologist.

21 So, you know, we do believe that this should be 22 within the hands of dermatologists, as they are the 23 gatekeepers for this particular patient population. 24 And if they're, you know, adequately and

25 appropriately trained and equipped and they have the

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1 support layers in there, there should be no reason for them to have it, to have it for access to their 2 patient population, safely and effectively. 3 4 CLARK ELDREDGE: Do you have a definition of 5 adequately trained? JOSHUA SWINDLE: That's a good question. 6 7 STEVEN SCOTT: What's the question? What is our definition of 8 JOSHUA SWINDLE: 9 adequately trained. We believe our, our physician 10 population is, you know, adequately trained. Thev 11 receive both the manufacturer training as well as a, 12 you know, pretty extensive clinical on boarding 13 training with our chief medical officer and 14 sometimes Dr. Yu, that goes over a lot of the 15 subjects that we have, you know, put in there. We have access or provide access for the physicians to 16 17 have ongoing training, whether it be weekly, 18 monthly, annually. So I'd be happy to give you some 19 information if you'd like.

20 STEVEN SCOTT: I mean, obviously, the training 21 that's happening for the dermatologists is not going 22 to suffice for the literal interpretation in Part X. 23 We all get that, right? But I think that we're all 24 smart enough to realize Part X was written for the 25 control of radiation with a linear accelerator,

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

5 But to your question, you know, how much is a enough training? Well, there's no such thing as 6 7 enough. They can always benefit from more training. And there's why having medical physicists and having 8 9 radiation therapists as part of the solution, really 10 helps round out that training for these 11 dermatologists. They can have all they want and 12 We're happy to go back in and retrain. more. We're 13 happy if they want to have the retraining from the 14 manufacturer all over again, although we have to pay 15 for that. We're happy to have the manufacturer come back and train them all over again. 16

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

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

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

7 We have had four medical events associated with 8 dermatological cancer treatments. Two -- well, one 9 I know, one was in an oncology center. Two were 10 actually SRT related and the third was electron 11 beam. And I don't remember if that was a 12 dermatological practice or not.

13 The two dermatological practices, it was wrong 14 site. The physician and -- he had just brought a 15 therapist on board to place him pushing the button. 16 And the therapist asked which mole was it? Which 17 spot on the skin it was? And he picked out the 18 wrong one.

19 STEVEN SCOTT: Yeah. You know, that does 20 happen. And God bless them, these patients, if they 21 have one, they've got 15. It's not a matter of if, 22 it's just a win. These are going to manifest. And 23 sometimes these patients come in, I mean, they are 24 just absolutely covered in skin cancers. So

25 identifying the wrong one can happen, certainly, you

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

5 You know, you work in radiation oncology long enough, you're going to treat the wrong site. 6 7 That's just the reality. That's happened in my background as well, in a cancer center, where even 8 9 though you questioned the physician, this doesn't 10 look to me like it matches the original picture. 11 Are you sure we're in the right spot? Yes, you are. 12 Right? So it does happen, unfortunately. Go.

13 But we really go the extra mile on the 14 documentation of what happens, so having the 15 physician and the radiation therapist on the front end actually, you know, triangulating the lesion on 16 17 the skin, using reference moles. Taking photographs 18 of that. The machine actually has a built-in camera 19 But we can take photographs and it gives as well. 20 you an opportunity to look at all of that.

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

1 one time when one of our physicists logged in and 2 looked at the photograph and said, that looks 3 different to me. That looks like something has 4 changed. What is going on here, right? And they 5 were able to message the RTT through the system and actually perform a lockout until it had been 6 7 acknowledged and been corrected. And it was 8 actually, the patient had multiple lesions within 9 the same field being treated. So everybody was 10 right in that instance, but it does happen.

11 The other thing that we, we really pride 12 ourselves on, and we really insist upon is that if 13 we know there has been a misadministration, the 14 practice will report it. If they don't, we will, 15 you know. Misadministrations happen all the time 16 and most don't get reported, sadly.

17 JAMES FUTCH: What was the other one? 18 CLARK ELDREDGE: The other one was two months' 19 worth of patients, potentially. Maybe more. Where 20 the machine was operating through -- 30 percent 21 under the rating. So when they thought they were 22 dosing, it was, the therapists were -- the machine 23 was drifting. The therapist would go and reset the 24 baseline on the machine, not knowing that that's 25 what they were doing, and so it kept drifting down.

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

3 STEVEN SCOTT: Yeah. CLARK ELDREDGE: And after it -- it was 4 5 actually captured by the annual calibration. So if the annual calibration had happened even later --6 7 STEVEN SCOTT: Yeah. So that's why we don't 8 wait for an annual. We do daily qA on all the 9 devices. And that's why the physicists can lock 10 them out remotely if they see a drift. 11 That was amazingly -- the CLARK ELDREDGE: 12 chart, the two-and-a-half months' worth of the daily 13 checks, that paperwork all disappeared. 14 STEVEN SCOTT: No. That could never happen. 15 CLARK ELDREDGE: They said they gave it to the doctor. 16 17 STEVEN SCOTT: And he ate them. 18 CLARK ELDREDGE: The doctor, he lost it. 19 STEVEN SCOTT: Yeah. 20 That one is waiting for legal. CLARK ELDREDGE: 21 STEVEN SCOTT: We would never condone somebody covering something -- the other great thing, too, is 22 23 because it is in the report and verified in the 24 system, they couldn't cover it up if they wanted to.

25 Honestly and truly, it's locked away forever. And

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

8 In addition to that, the manufacturers test the 9 tolerance at about 3.5 percent deviation. And we 10 have them lock it down to 2 percent deviation for 11 us.

12 CLARK ELDREDGE: Okay. The machine was getting 13 the 3, 3 percent.

14 STEVEN SCOTT: Yeah.

15 CLARK ELDREDGE: Why they had a key, I don't 16 know.

17 STEVEN SCOTT: You know, we see a lot of stuff 18 out there in the industry. And that's, you know, 19 again, that's part of why we created this endeavor 20 because we thought there should be some 21 standardization. Radiation protection is incredibly 22 important, obviously. Patient outcomes matter, you 23 And it's just not something you can half ass. know. 24 DR. RANDY SCHENKMAN: Well, thank you so much. 25 That was a great presentation. I think we all

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1 learned from this.

2 JAMES FUTCH: We had a lot of nice questions. 3 DR. RANDY SCHENKMAN: Yeah. 4 STEVEN SCOTT: Well, thanks. And certainly, we 5 want to be good partners. We appreciate it. 6 JAMES FUTCH: 7 STEVEN SCOTT: As you guys do decide to make changes or updates, if there's anything we can 8 9 assist with. We actually enjoy doing stuff like 10 We would love to help you all with anything that. 11 you're working on with regard to your regs or 12 anything you might be considering for training in 13 the future. And/or we really pride ourselves on the 14 way that our centers operate. And, you know, field 15 trips are always available. If anybody wants one, 16 even in this weird Covid world, we will, we will 17 figure out and you can come spend a day and see how 18 patients get treated if you would like. Okay? Well thank you all very much for your time 19 20 today. 21 ALL: Thank you. 22 STEVEN SCOTT: We really appreciate it. 23 (Applause) 24 STEVEN SCOTT: We're going to try to get to the 25 airport.

1 DR. RANDY SCHENKMAN: Well, it's lunch break 2 time everybody. 3 JAMES FUTCH: Coming back at 1 o'clock? 4 DR. RANDY SCHENKMAN: Yeah. We're going to 5 come back at 1 o'clock, if that's okay with 6 everybody. 7 (Proceedings recessed at 11:58 a.m.) (Proceedings resumed at 1:15 p.m.) 8 9 DR. RANDY SCHENKMAN: If it's okay with 10 everybody, we're going to get started. We're going 11 to give them a little more of a chance to set up. 12 So, Clark? 13 CLARK ELDREDGE: I have -- is there any 14 discussion further to follow up on the SkinCure 15 stuff? Any thoughts folks have? 16 ADAM WEAVER: How many of those operations do 17 you have in the State of Florida right now, 18 approximately? 19 CLARK ELDREDGE: For what they have versus what 20 we have, I have 85 registered superficial therapy 21 units. Well, that are -- the one, yeah. And 22 then -- let me look at that number. 23 ADAM WEAVER: Oh, just a ballpark. 24 CLARK ELDREDGE: Yeah. There's one Orthovolt 25 still out there and, like, eight Grenz Ray.

1 ADAM WEAVER: You still have one of the old 2 Orthovolts? 3 CLARK ELDREDGE: Yeah. 4 ADAM WEAVER: Wow. 5 MARK SEDDON: The Census SRT 100s are like a 50 some or 60 some. It's on the website. They've got 6 7 a very small base, which is what they're using in Florida --8 9 CLARK ELDREDGE: Right. 10 MARK SEDDON: -- or a variation of what they're 11 using. 12 ADAM WEAVER: I remember the other the old 13 Orthovolt machines used to be huge. Almost take up 14 a whole room. 15 CLARK ELDREDGE: 75 SRT 100s. ADAM WEAVER: The new tube technology makes 16 17 them smaller. 18 CLARK ELDREDGE: Now, with the -- again, the 19 difference between how it's regulated as far as 20 potentially an SRT unit could be a brachy, right? 21 It all depends on whether it's -- whether it is a 22 dose of up to a few centimeters by inner cavity, 23 intermural or interstitial or by application of the 24 source in contact with the body surface or very 25 close to the body surface. So it still comes down

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to what's definition of close to the body surface.
ADAM WEAVER: Do you have a definition for
that?

4 CLARK ELDREDGE: No, we don't. That's the 5 problem. You know, so if the -- I saw one thing 6 where it said, one of them was talking about being 7 30 centimeters from the source of the skin. So it's 8 12 inches. So I'm looking at the machines. I'm not 9 sure how they're that far away.

10 ADAM WEAVER: That seems far away.

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

13 MARK SEDDON: They have a cone.

14 CLARK ELDREDGE: They have a cone you put on 15 the end for shaping and so that puts a little bit 16 space in there.

17 MARK SEDDON: Yeah.

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

24 CLARK ELDREDGE: So, yeah.

25 ADAM WEAVER: Yeah.

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CLARK ELDREDGE: It's an articulated head. 1 2 ADAM WEAVER: They have some kind of jig or 3 something. 4 GEORGE GILBRIDE: To keep the head from moving. 5 CLARK ELDREDGE: Yeah. Just lock it in place. You have to sit real still and move the head around 6 7 and --8 ADAM WEAVER: Like a dental --9 GEORGE GILBRIDE: Cataracts type of thing 10 maybe. 11 I had a new dentist and they took x-rays. 12 Handheld x-ray units. Oh, my God. I'm sitting 13 there and I'm thinking, all I kept going was, are 14 you F-ing crazy? I've been in radiology since 1978, 15 I'm thinking, it's like, you know, and, this is 16 nuts. Okay. Enlighten me. 17 CLARK ELDREDGE: Handheld tubes. JOHN WILLIAMSON: We had a whole discussion on 18 19 those. 20 CLARK ELDRIDGE: Yeah. 21 GEORGE GILBRIDE: I'm sorry? 22 CLARK ELDREDGE: They're actually -- um, the 23 FDA, the handheld machines have been through the FDA 24 process. 25 GEORGE GILBRIDE: Okay.

1 CLARK ELDREDGE: The operating position is 2 quite protected. They have the scatter shield 3 mounted at the end of it. And so, there's no 4 particular possible risk of the operator if 5 everything is set up right. We're seeing anywhere near regulatory doses. So that's on the good side. 6 7 They are running it a couple milliseconds. Again, we're talking about ones that are marketed, built 8 9 specifically for the U.S.

10 ADAM WEAVER: You're talking dental ones or --11 CLARK ELDREDGE: Dental.

12 ADAM WEAVER: -- or XRS?

13 CLARK ELDREDGE: Dental. We switched to14 handheld dental. They are running at 60 to 70kV.

15 One of the good things, real short peak, of 16 course, is to get a decent image. If they went for 17 any longer they have a hard time --

18 GEORGE GILBRIDE: 60 kVs, they still have to go 19 through the enamel of the teeth.

20 CLARK ELDREDGE: No, that's standard. That --21 well, actually, we'll talk in a little bit about in 22 my section.

23 GEORGE GILBRIDE: Okay.

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

1 handheld operators because it's the only way to know if there's something goofy going on, right? 2 3 ADAM WEAVER: You're talking handheld dental 4 units. Only dental. 5 CLARK ELDREDGE: Well, actually, any -- nobody else is supposed to be using a handheld tube. 6 7 ADAM WEAVER: Analytical, the XRFs. CLARK ELDREDGE: Yeah, but XRFs, but in that 8 9 case, that's true. I should have -- yeah. An XRF, 10 the only case of being of a real risk there is when 11 people will hold the material you're shooting rather 12 than --13 ADAM WEAVER: Keeping it in the configuration 14 or the --15 CLARK ELDREDGE: Yeah. Using it how they're They're doing it without 16 supposed to use it. 17 training. They had -- I reported this a while back 18 where we had a wife rat out her husband who bought a machine not registering it. He'd been using it for 19 20 a few years, holding the jewelry in his hand and was having nerve damage to his hands. And so they --21 22 that's -- she was not happy with it. 23 ADAM WEAVER: So she blamed the nerve damage on 24 radiation damage?

25 CHANTEL CORBETT: It was.

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

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

8 ADAM WEAVER: Check the old fluoro tubes. Get 9 the orientation, remember the old reverse ones, the 10 green ones?

11 CLARK ELDREDGE: All right.

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

14 JOHN WILLIAMSON: I'm going to start off with 15 giving you a little story. In the late summer of 2018, Hardee County asked us, because of citizen 16 allegations, if there was radioactive material in 17 18 one of their county parks, to do a survey of their 19 This was Hardee Lakes Park, which was donated park. 20 to them by Mosaic, which was one of the largest phosphate mining companies in the world. So we 21 22 agreed to do a survey. They were particularly 23 concerned about phosphate reject rock, which is rock 24 that is not of quality enough to go through the 25 phosphate extraction process.

1 So we went through with our Radiation Solutions 2 mobile radiation detection system. We drove every 3 single road in the park. We also went in all in the 4 areas where there was campsites. We went in the 5 off-road areas. We made an analysis of what we 6 found.

7 And on the roads, typically we're finding 8 exposures of about -- sorry, I know you guys are 9 medical. I'm used to dealing with English -- about 10 15 microR per hour. We found some areas as high as 11 36 microR per hour. These are compared to normal 12 backgrounds of 6 to 10 microR per hour.

13 So we wrote a letter to the Hardee County 14 manager, that based on NCRP 116, which is the 15 exposure the public to naturally occurring radioactive material, we didn't believe that the 16 17 minor amount of time that most people spend at a 18 county park was going to accumulate more than 100 19 milligram a year of dose, which is the criteria for 20 NCRP 116. If it's a 100 milligram or more above the 21 normal background, you might consider doing 22 something about it. Our calculations were that 23 somebody who stayed there on the order of 30 days a 24 year will get, I think, 10 to 15 milligram of

25 additional exposure.

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1 Anyhow, so that was all 2018. Earlier this 2 summer, I got an inquiry from two reporters working 3 on a documentary from CNN, who were interested in 4 the work that we had done. They disagree with the 5 methodology and the conclusions that we came to on They asked to do interviews 6 that particular park. 7 with -- the Department doesn't typically allow any 8 of that type to take place.

9 At some point, I expect in the next couple 10 months, there will be a documentary on this. And I 11 just thought you guys deserve to at least hear about 12 it before you see it. Since you're on the Advisory 13 Council, it will be nice that somebody told you that 14 hey, by the way, you might see something.

15 If you have any questions, I'll be happy to 16 answer it. Afterwards will probably be better 17 because we're a little short on time here.

18 So the next thing I want to talk about is the 19 instrument, the equipment updates that we've taken 20 for the Bureau. This is an R200. It's actually a 21 spectroscopic personal radiation detector. But in 22 essence, what it really is is a RID, relay isotopic 23 identifier, that tells you what gamma isotope you're 24 dealing with. The current method by which we respond to radiation incidents is we receive a call 25

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from our duty officer in Orlando. He calls a 1 regional duty officer who typically goes out and 2 3 makes the response. If the response looks like it's 4 going to need isotope identification, that duty 5 officer has to drive to the storage shed maintained by each of those regional locations, which could be, 6 7 you know, in Miami traffic, could take you two hours to get to the storage shed, which obviously, means 8 9 that the amount of time that it takes us to respond 10 to a radiation incident could be a significant 11 amount of time.

12 So what we've decided to do, we bought one of 13 these for each one of the regional duty officers, so 14 when they're on call, they will have this with them 15 all the time. So they don't have to drive to the storage shed to pick up the RID. 16 This gives us 17 probably only about 70 percent of the total capacity 18 because the RID they have in the storage shed is a much larger detector. This is a much smaller 19 20 detector. But for most of what we do, it's more 21 than adequate. So we're cutting down the amount of 22 time that we're going to spend taking to respond to 23 radiation incidents.

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

1 inspectors, for the most part, have smart phones. 2 They can actually connect to this device with their 3 smart phone and they can send that spectra off to us 4 and we can send it to the Department of Energy to 5 actually have reach back concern. In that same time, they can get another person from the office 6 7 who can go to the storage shed, pick up the more advanced RID and bring it back so they can do an 8 9 additional spectrum on it.

10 JOSEPH DANEK: What's is that unit called? I'm 11 sorry.

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

16 ADAM WEAVER: Cesium iodine?

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

19 lutecium --

20 ADAM WEAVER: Oh, yeah.

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

24 We've also, we do a lot of PRD, preventive rad 25 nuke detection. We talked about that in the past,

1 monitoring the Super Bowl, of the Daytona 500. We 2 do a lot of that, carrying backpacks with large 3 radiation detectors on our back. Previously, the 4 ten backpacks we had only would tell you what the 5 radiation dose rate was. It wouldn't tell you what 6 the isotope is.

7 Over the last year, we purchased two of these backpacks from Radiation Solutions, Incorporated, a 8 9 company in Canada. Same company that make our 10 mobile radiation detection systems. This one has 11 two cesium -- no, two sodium iodine detectors and a 12 neutron detector. So these actually will give us an 13 ID as well as telling us what the gamma dose rate 14 is.

15 So where you see an instance for using this, if you're -- for instance, we did monitoring at the 16 17 Fort Lauderdale International Boat Show at the end 18 of October and we -- they have, I think, seven or 19 eight separate gates. So we put one of these at the 20 gate with one of our personnel. When somebody comes 21 through, normally, it would've been that would set 22 off an alarm. We'd have to get our RID. We'd have 23 to go stop them, ask them to hold and we'd do a 24 five-minute count before we'd be able to ID.

25 These, because of the size of the detectors,

1 they're three-inch sodium iodine detectors, they can actually give us an ID usually just by somebody 2 3 walking by. They had, I think, about 15 alarms. 4 All of them happened to be medical alarms. This one 5 will ID in a very, very short amount of time. So it means you don't have to go catch the person, unless 6 7 it shows up as a -- one of the things, for instance, if somebody goes by and it's medical, we're not 8 9 concerned about. If somebody goes by and it's 10 cesium, we start to get a little more upset. Ιf 11 somebody goes by and you get a neutron alarm, then 12 you start thinking, you know, possible nuclear weapons. 13

14 So anyhow, so what I've done is I brought a 15 number of different check sources. I think six 16 different gamma isotopes. So you are welcome to 17 come up and actually take ahold of the instrument 18 and take a look at what -- how they operate. And we 19 can also bring stuff by this one. You can see what 20 the gamma ID is.

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

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1 think anything different. 2 JOSEPH DANEK: So come up and do it? 3 JOHN WILLIAMSON: Yeah, sure. 4 ADAM WEAVER: You're the environmental guy. 5 You're supposed to do it. JAMES FUTCH: You have a question? Giovanna 6 7 has got a question. 8 GIOVANNA MANNING: I want to know, that's an 9 app that --10 JOHN WILLIAMSON: Yes. 11 GIOVANNA MANNING: -- the Bureau made, we made 12 it? 13 JOHN WILLIAMSON: No. It's made by the 14 company, the manufacturer. 15 ADAM WEAVER: No, from the vendor. 16 GIOVANNA MANNING: Okay. The vendor. 17 JAMES FUTCH: It is available to put on your 18 phone and it's even approved by the Department. 19 JOHN WILLIAMSON: Yes. We went through all the 20 rigmarole to get it approved by the Department. 21 ADAM WEAVER: Does this actually show you a 22 spectrum? 23 JOHN WILLIAMSON: Yes, it does. And you can 24 actually do it on your phone as well, but I didn't 25 bring a phone for it.

1 CHANTEL CORBETT: Do you know what the price 2 tag is on the R200? 3 JOHN WILLIAMSON: Which one? 4 CHANTEL CORBETT: R200. 5 DR. NICHOLAS PLAXTON: Twenty bucks. JOHN WILLIAMSON: \$3800 with the neutron 6 7 detector. DR. NICHOLAS PLAXTON: Which one? That one? 8 9 JOHN WILLIAMSON: No. This one. 10 MARK SEDDON: No, this one. 11 DR. NICHOLAS PLAXTON: How much is that one? 12 JOHN WILLIAMSON: \$31,500. 13 MARK SEDDON: Yeah, I was going to say. 14 CHANTEL CORBETT: I was like probably add 15 another zero on that. Yeah, the other RIDs are much bigger. 16 17 DOUGLASS COOKE: I thought my kid's backpack 18 was expensive. 19 JOHN WILLIAMSON: And then this one, the middle button on there, that means --20 21 JAMES FUTCH: So the one on the right has a 22 super tiny screen. You better know what button does 23 what before you touch it. 24 JOHN WILLIAMSON: Yeah, it's definitely meant 25 for the younger --

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

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

8 GIOVANNA MANNING: The R200 does not have an 9 app?

10JOHN WILLIAMSON: Yeah, the R200 has an app as11well. It's not a mirror image. It doesn't show you12exactly what the screen does.

13 (Off-the-Record Review of Equipment Updates)
 14 DR. RANDY SCHENKMAN: Thank you so much. John,
 15 thank you so much for your presentation. That was
 16 great.

17 JOHN WILLIAMSON: You're welcome.

18 ADAM WEAVER: Thank you, John. Nice toys.

19 (Applause)

20 DR. NICHOLAS PLAXTON: I feel safer now.

21 ADAM WEAVER: I can go to the next Super Bowl 22 and feel --

23 CHANTEL CORBETT: That was what was holding you24 back.

25 ADAM WEAVER: That was what was holding me

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1 back.

2	CHANTEL CORBETT: Not the ticket price.
3	DR. NICHOLAS PLAXTON: Yeah, right?
4	ADAM WEAVER: No, no, no. It was fear. The
5	last one was in Tampa. It was the first time a home
6	team This year it's in Los Angeles.
7	DR. RANDY SCHENKMAN: Okay. Do you want to go
8	next? Clark, do you have more you want to do?
9	CLARK ELDREDGE: No, I'm good. Until my turn.
10	JAMES FUTCH: All right.
11	DR. RANDY SCHENKMAN: Wait. Should we have
12	Douglass go first?
13	JAMES FUTCH: You're up, Douglass.
14	DOUGLASS COOKE: Good afternoon, everybody. If
15	I can direct you all to the last three pages of the
16	package you have in front of you. Again, since I am
17	the replacement Brenda today, I will be handling her
18	task of trying to set up our next meeting.
19	Yes, sir?
20	CLARK ELDREDGE: You asked me if I had more
21	stuff to cover from my group?
22	JAMES FUTCH: No.
23	CLARK ELDREDGE: We're doing that
24	DOUGLASS COOKE: Because I have to drive to the
25	yeah. So availability is March, April and May.

1 If anybody has the time that they're --2 DR. RANDY SCHENKMAN: April or May would be 3 better for me. 4 DOUGLASS COOKE: Okay. So Dr. Schenkman has 5 requested we skip March, so we'll just go to April or May. And we're waiting on an update about a --6 There's a Florida Health Physics 7 ADAM WEAVER: 8 Society meeting. 9 DOUGLASS COOKE: That's important too, yes. 10 JOSEPH DANEK: That's supposed to be April 7th. 11 ADAM WEAVER: Okay. 12 CHANTEL CORBETT: On a Thursday? 13 ADAM WEAVER: It starts Thursday and the 14 meeting is on Friday. 15 So we'll skip past the first DOUGLASS COOKE: week of April. You can all think about me that day 16 17 since it's my birthday while you're there. Thank 18 you. 19 ADAM WEAVER: When's your birthday? 20 DOUGLASS COOKE: April 6th. 21 ADAM WEAVER: Mine's the 7th. 22 GEORGE GILBRIDE: Mine's the 8th. 23 DR. RANDY SCHENKMAN: Look what I started here. 24 (Laughter) 25 DOUGLASS COOKE: That's puts us in the second,

1 third or fourth week of April or any time in May. 2 Does anybody else have anything going on or --3 GEORGE GILBRIDE: Easter's our anniversary, but 4 that's fine. 5 DOUGLASS COOKE: So schedule it for the 23rd. 6 Yes, sir. Gotcha. 7 JAMES FUTCH: So may has --CHANTEL CORBETT: I'd April 21st or --8 9 DOUGLASS COOKE: Yeah, I was going to say --10 ADAM WEAVER: Or the 28th. 11 REBECCA McFADDEN: The 28th looks better. 12 JAMES FUTCH: How about Tuesdays or Thursdays? 13 There used to be a big dichotomy between Thursdays 14 and Tuesdays. 15 I like Thursday. WILLIAM ATHERTON: John? JOSEPH DANEK: The last week of April is bad 16 17 for me. Last week of April. 18 DOUGLASS COOKE: Last week of April is bad for 19 How about the 21st? That's a Thursday. you? Is 20 everybody okay with the Thursdays? 21 DR. NICHOLAS PLAXTON: I can't make the 21st. 22 DOUGLASS COOKE: Okay. Let's go to May people. 23 DR. RANDY SCHENKMAN: Are Tuesdays good for --24 DOUGLASS COOKE: Tuesdays better? 25 REBECCA McFADDEN: The 12th or the 19th.

1 ADAM WEAVER: April 19th. 2 JOSEPH DANEK: Tuesday the 19th. 3 DR. RANDY SCHENKMAN: Is Tuesday the 19th good 4 for everybody? 5 CHANTEL CORBETT: Okay. GEORGE GILBRIDE: 6 April? 7 JAMES FUTCH: It's two days after Easter. GIOVANNA MANNING: I hope it's good for Kevin. 8 9 ADAM WEAVER: Once you come, you've got to keep 10 coming. 11 DOUGLASS COOKE: Yeah. Listen, I tried to get 12 I wasn't here for, like, three times and they out. 13 drug me back in. So we're going to go April 19th? 14 DR. RANDY SCHENKMAN: So we're going to do 15 Tuesday, April 19th for our next meeting. Okay? 16 CHANTEL CORBETT: That sounds good. 17 GEORGE GILBRIDE: Put that in my phone. 18 DR. NICHOLAS PLAXTON: Same place? 19 DOUGLASS COOKE: It will be in this area. 20 Hopefully we'll try to get this hotel again. 21 Obviously, Hilton owns all three of them. So it 22 will be at one of these three. 23 DR. NICHOLAS PLAXTON: Okay. Got it. 24 DOUGLASS COOKE: I kind of enjoyed the 25 breakfast this morning, so I'll put --

DR. NICHOLAS PLAXTON: I missed it. It ended 1 2 at 9. I was hoping, I was planning on it. They 3 always have a free breakfast. Usually they go to 4 10. 5 DR. RANDY SCHENKMAN: Are there any other 6 updates for you? 7 DOUGLASS COOKE: I did not have any other -oh, yes. Your, your travel is all still pending. 8 9 There was a kerfuffle. That will be a good word for 10 today. Kerfuffle. 11 GEORGE GILBRIDE: Watch your language, young 12 man. 13 DOUGLASS COOKE: Yes, I will try. Next 14 meeting, I will. So basically, what's going to 15 occur is we'll get everything put together and sent out to you all for signatures. It should be, if not 16 17 tomorrow, it will be the first part of next week. I 18 know Brenda's back in the office on Monday, so you 19 probably don't expect it before then. And we'll 20 just make sure everything gets taken care of with 21 one, one transaction. 22 DR. RANDY SCHENKMAN: E-mailing it to everybody 23 or mailing? 24 DOUGLASS COOKE: It will be e-mailed just for 25 your signatures and then we can print and scan and

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

7 DR. RANDY SCHENKMAN: Okay.

8 DOUGLASS COOKE: Anything else for me? No? 9 DR. RANDY SCHENKMAN: So, Clark, do you want to 10 finish?

JAMES FUTCH: Then go on to your stuff.
CLARK ELDREDGE: Okay. Go ahead with mine?
Okay. So then we have just the radiation machine
updating section. All right?

15 The machine update. We've just -- well, we're not finished with the annual renewals, but we're 16 17 through with the people who bothered to register on 18 time. We're currently 85 percent of all the 19 registrations, 19,500 or so. Eighty-five percent of 20 them have submitted their money and have been issued 21 their registrations. Things actually went pretty 22 well this registration period, even though we had 23 one of our staff guit at the very beginning.

24 GIOVANNA MANNING: So that's why I was doing so 25 much work.

1 CLARK ELDREDGE: And Miss Manning gets kudos 2 for the boxes of -- for the trays and trays of 3 checks and payments she approved for processing. So 4 she's a huge help for us.

5 So we're down to, yeah, fifty to a hundred 6 renewals as they trickle in a day. And we'll be 7 sending out our second notices in a couple weeks. 8 We usually send out second notices around 15 -- 10 9 to 15 percent left, so we're about that point right 10 now.

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

14 We currently have 617 ACR accredited 15 mammography facilities in the state; five provisional, although this year, we're contracted to 16 17 do 671 inspections for this year. Part of that is 18 to make up for the pandemic shut down. So we're, 19 you know, so the folks that were being inspected --20 MQSA requires people to be inspected between 10 and 14 months. MQSA, between 10 and 14 months from the 21 22 last inspection. Ideally, you're trying to hit the 23 12-month mark, one year.

24 So with the 671 inspections, those folks that 25 were inspected at the beginning of our contract year

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

7 They are also proposing that they're going to 8 realign all the contracts so they all end on the 9 same day. Things tend to creep and out of sight. 10 (William Atherton Leaves the Meeting) 11 CLARK ELDREDGE: So they're going to --12 currently, our contract is September 1st to August 13 31st.

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

21 We are currently the second largest program in 22 the U.S. Second largest number of facilities. And 23 we're still -- we're short currently one inspector. 24 We were down about three qualified inspectors. We 25 were able to get two through the last training. One

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

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

7 Medical events, we've had two since last meeting. We have -- one was a rather difficult 8 9 pancreatic treatment with a lot of soft tissue. 10 They had trouble get all the markers aligned as they 11 prepped the thing. So that was a wrong site. The 12 other one was just reported just before 13 Thanksgiving, and so I don't know the details on 14 that one yet. I haven't seen the facilities report. 15 Enforcement investigations going on for us, DEXA sales and referrals. Companies that are out of 16 17 state selling health coaching services and, you 18 know, getting you in shape and referring you to 19 in-state DEXA providers to get you DEXA scans to see 20 how you're progressing on your exercise regimen. 21 ADAM WEAVER: Someone else to yell at you. 22 So we're currently -- of the CLARK ELDREDGE: 23 various DEXA folks that were on the list, from 24 the -- for referrals, most of them were folks that

25 we've already been working on because they are also

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1 selling it as DEXA scans as part of the personal weight loss, personal body, whatever type. 2 3 GEORGE GILBRIDE: Body fat. 4 CLARK ELDREDGE: Yeah. These are all about 5 body fat measurements rather than bone density. But they actually have licensed practitioners in the 6 They work with -- we've gone with them to 7 office. make sure that they are following proper -- our 8 9 legal requirements because there's no such thing as 10 a non-medical x-ray in Florida other than the 11 limited security allowances in the, in the jails for 12 prisoners. So that's -- everybody else is medical. 13 There has to be a physician who authorizes it; who's 14 using it as part of your health care treatment in 15 our statutes. So, you know, so this one place, one of the 16 17 people we worked with actually goes and they don't 18 give you the result right then when you walk in.

19 They actually, it has to go to the physician's staff 20 office to review it and whatever recommendations 21 they give, you know. Normal kind of medical review 22 of the report and provide back.

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

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1 be a doctor authorizing these x-rays.

2 GAIL CURRY: Hmm.

3 CLARK ELDREDGE: And the other one was a gym in 4 the Tampa area, which apparently doesn't have the 5 machine, but they were on their site. So that was 6 interesting that they were having a, a gym listed 7 but --

GEORGE GILBRIDE: Was it a mobile? 8 9 CLARK ELDREDGE: No. We don't know the 10 details. Just -- we have -- we're pursuing more 11 cases where facilities are selling subscriptions to 12 full-body CTs. Come get your annual full-body CT. 13 We'll give it to you and then we'll send the results 14 to your primary care and we're not going to do a 15 thing with it. Yes, we'll send it to radiologists but we're not going to follow you up with it. 16 17 DR. NICHOLAS PLAXTON: That's messed up.

18 CLARK ELDREDGE: And so, we had -- a couple 19 years ago, we had a facility in this area who was 20 looking to buy their own machine to do this. Right 21 now, we've got one group in town right now that's 22 selling them, but they're referring people to 23 diagnostic centers, which is a little bit more about 24 our ability to enforce that. Since the person 25 owning the machine, it looks to them like it's part

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

4 And unfortunately, I found there are two more 5 facilities in Florida which were not recognized that's what they were doing and they currently have 6 7 registrations. So we have to go back and work back with them to find out how they're complying with 8 9 44.22 paragraph 8. I think it's 8, not 7, which 10 says, again, the doctor's got to be involved with 11 it. He's got to order your x-ray and provide you 12 with medical care through the results of that x-ray.

We continue to find more of the non-FDA 13 14 compliant handheld dental units. This was a -- now, 15 the last two were veterinary units, were in veterinary practices, which don't have to meet the 16 17 same standards for human exposure, but they have to 18 meet the standards for operator safety. And they 19 don't meet the standards for operator safety. So, 20 you know.

21 We are working on some draft language for 22 rules, as always. One of the other recent things 23 we've had is with the industrial -- mobile 24 industrial radiography rooms. People want to claim 25 they're cabinets, but we're talking something that's

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ten by ten or larger. People walk in, they dump 1 stuff in there, they walk out and close the door. 2 3 Our codes require them to be industrial 4 radiographers to operate these systems. And of 5 course, the people who register them think they're only cabinet machines and don't require the 6 7 appropriate training for their employees to operate the machines. 8

9 And our language in our statute doesn't -- in 10 our rules, doesn't quite clearly draw the line 11 between the cabinet and something you could walk in. 12 Because the actual machine website, the manufacturer 13 in this case is Nikon. Their thing doesn't describe 14 it as a cabinet as all. The register is calling it 15 a cabinet. And they call it a walk-in x-ray room. A radiography room is what they call it. 16

17 But then we have other -- but then again, you 18 look at some other sites selling these -- this type 19 of equipment. They call it a walk-in cabinet, so --20 One thing that we can use help with, if anybody 21 on the committee has any insight, references, 22 resources, with our statutory updates, trying to 23 re-envision the registration scheme and standard. 24 Currently, of course, the registration is linked 25 primarily to who's operating the machine and not the

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1 hazard.

2 I had written language that was -- and 3 submitted it up to try to change it from is it a 4 doctor, is it a vet, is it an educational facility, 5 to is a human being put into the useful beam or not. Or is an accelerator. That's specified in there. I 6 7 think that's fine to differentiate accelerators in that way. Or -- and then with the techs versus the 8 9 doctors, the question becomes, yes, you have 10 somebody being put in a useful beam, but what's the 11 actual dose rate from the machine, what's the 12 potential of the tube; things like that. 13 Originally, you're looking at the potential for the 14 tube, but that doesn't work out so well because 15 while dental units are working at 70kV, you have mammo at 30kV, and you have extremity CTs that are 16 17 working down at 50kV. And those things are putting 18 a lot more dose through the person than dental is. 19 So -- and that's sort of, if you look at the history and you look, of course, all regs are based in the 20 21 1980s.

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

1 So as usage of machines have changed, I'm trying to 2 propose language. It was rejected last time we put 3 it through, just because it also involves language 4 that affects the fee structure. Because the fee 5 structure, itself, is tied to who's operating the machine. And now they want to tie the fee structure 6 7 to the risk from the tube to the person and the 8 operators.

9 Not that we want the fee structure to change 10 any. We just need to reword it to reflect it and 11 that's what killed it before. But if anybody has 12 any good way to reference resources they feel would 13 be useful for trying to find the right language to 14 split between the dental podiatry section and the 15 rest of the medical, it would be useful.

I've been trying to research things, reference 16 17 documents from ACR, from IAEA, from many of the 18 other reference exposure studies and things like 19 that, to figure if there was some good value to park 20 there, and it's not really clear when you look at 21 these things. There's rather large bands and things 22 like that, so we're trying to find a good measure to 23 be able to make that break point between the 24 five-year inspection cycle between the very simple 25 podiatry, dental-type operations versus things that

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

3 So again, anything you all have, any resources 4 or something you all can think of or come up with, 5 please let us know. Let me know so I can look at it 6 and bring you all back something to --

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

11 CLARK ELDREDGE: And that's the other thing. 12 We do need to expand the registration categories 13 more because the free-standing emergency rooms and 14 those things, we don't -- that, now fortunately, 15 that's a rule thing rather than, you know, and the fees will still be the same. But we do need to add 16 17 more categories for the surgery centers and the, the 18 emergency room, urgent care facilities. Because 19 they're not hospitals and they're not doctors' 20 offices. And that's the -- that was the choice to 21 flip the coin on. So --22 So talk to them about it. MARK SEDDON: 23 CLARK ELDREDGE: Yeah, we definitely -- I would

appreciate your insight on it. We definitely need
to talk about it. All right. I think that covers

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1 everything I had on my list. Any questions, any 2 inspiration? 3 Just, I talked to you about ADAM WEAVER: 4 the -- when people are using lead aprons. Your 5 draft. CLARK ELDREDGE: So I do have to talk about 6 7 that now and I want to know if you all agree to endorse it. Do we have the form still? 8 9 CINDY BECKER: We do. 10 CLARK ELDREDGE: So the -- do we all have 11 copies of the latest drafts? ADAM WEAVER: You e-mailed them to us. 12 13 CLARK ELDREDGE: Everybody, if you can take a 14 look at them. 15 JAMES FUTCH: Clark, I can pull them up if you 16 want to. 17 CLARK ELDREDGE: Yeah, why don't we pull them up. That would be easier. 18 19 JOSEPH DANEK: I've got a couple comments on 20 it, too. The dose weighting factor as well as the 21 apron. 22 ADAM WEAVER: You probably have the same 23 comment I do. 24 JOSEPH DANEK: We'll see. Oh, no, mine is 25 different.

1 ADAM WEAVER: Is what? 2 JOSEPH DANEK: Yours is the gonad or apron? 3 Same thing as apron? Dose weighting 4 factor. 5 ADAM WEAVER: Yeah. Well, it's not appropriate for x-rays. 6 7 CHANTEL CORBETT: Right. They ruled that out in the last one. 8 9 ADAM WEAVER: Yeah. Alternate double T's. 10 JOSEPH DANEK: What's gone? 11 CHANTEL CORBETT: Gonads. 12 JOSEPH DANEK: You can't use them any more? CHANTEL CORBETT: You can but it's not 13 14 recommended. 15 JOSEPH DANEK: This thing is going to come out? ADAM WEAVER: Well, it's just a draft right 16 17 now. 18 JAMES FUTCH: Which one do you want? The dose weighting factor is 19 ADAM WEAVER: 20 first for me. Joe did an internal dosimetry --21 JOSEPH DANEK: Yeah, that's the one. 22 JAMES FUTCH: Clark, which one is that in? 23 ADAM WEAVER: It's number four. 24 CLARK ELDREDGE: Number four. 25 ADAM WEAVER: Information notice number four.

1 CLARK ELDREDGE: Yeah. Because that's the 2 revision. Information number four was originally 3 released, basically specifying the calculation and 4 the appropriate -- that we didn't really have the 5 authority in that, so it was withdrawn and never really updated. So even though everybody was kind 6 7 of still following it, because there really aren't that many peer-reviewed approved methods for 8 9 adjusting, correcting or weighting the dose for 10 using aprons. 11 ADAM WEAVER: But there's probably 40 different

12 methods. Actually, I have 11 right here on the 13 paper.

14 CLARK ELDREDGE: Wow. I had not seen all 15 those.

Yeah. This was published -- I 16 ADAM WEAVER: 17 don't know what date. I didn't put the publish 18 date. But I guess my main concern with, do we have to use WT? Because all you're modifying is the 19 20 effective dose equivalent. And you're just using a 21 correction factor. Whatever's appropriate for your 22 site, whether you're using one badge at the collar 23 or wearing two badges. One at the collar, one at 24 the mid section under the apron.

25 CLARK ELDREDGE: Right.

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1 ADAM WEAVER: So, you know, and it depends, you There's so many different variables. 2 What's know. 3 the thickness of your apron? Is everybody wearing 4 the same thickness? It may be true; may not. Some 5 doctors buy their own aprons because it may be more comfortable for them to have a two-piece one versus 6 7 a single piece. There's all kind of -- there's so 8 many variations. And then there's a complete wrap 9 around, so there's so much -- but I just -- I don't 10 -- you know, doing a lot of internal dosimetry, the 11 weighting factors, really, only applied for internal 12 dose. 13 CHANTEL CORBETT: So more of a correction 14 factor. 15 ADAM WEAVER: Yeah. It should be just called a correction factor. 16 17 CHANTEL CORBETT: Yeah. ADAM WEAVER: And Landauer calls theirs --18

19 CHANTEL CORBETT: A correction.

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

his or her assistant. That's it, you know, be close 1 enough to the patient, or maybe on the other side of 2 3 the patient because you get a lot of scatter. 4 CHANTEL CORBETT: Yeah. 5 ADAM WEAVER: And these lead aprons only do good or offer any protection factor if you're 6 7 wearing them properly and only if it's scattered 8 x-rays, not --9 CHANTEL CORBETT: Correct. 10 ADAM WEAVER: -- nothing to do with the primary 11 beam or -- and let's face it, most x-ray tubes don't 12 have much leakage nowadays based on their design. 13 So I was hoping we could change it to correction or 14 correction factor. 15 CLARK ELDREDGE: All right. 16 CHANTEL CORBETT: Second. 17 ADAM WEAVER: Huh? 18 CHANTEL CORBETT: I second that. 19 If you want, I can give you the ADAM WEAVER: 20 reference for the 11 different methods. 21 CLARK ELDREDGE: Yeah. I'd like to have that 22 anyway, but I won't need it for this. But, yes, I 23 would appreciate that. We'll need to include that. 24 ADAM WEAVER: I was amazed when I found it. I mean there's table one, algorithms for calculations 25

1 of effective dose.

10

2 CLARK ELDREDGE: All right.

3 ADAM WEAVER: So I don't forget to give it to 4 you, I'll give it to you now.

5 CLARK ELDRIDGE: So I'll work through replacing alternative WT with the correction to, you know, a 6 7 correction to -- you all can chime in, too.

ADAM WEAVER: Because, you know, there's an NRC 8 9 regulatory guide on this issue. 8.4.

CLARK ELDREDGE: No, I didn't know that. 11 ADAM WEAVER: Methods for measuring effective 12 dose equivalent from external exposure. It was 13 published, I guess, July 2010. I don't believe 14 there's any update. And there's an NCRP on this. I 15 believe there's an ICRP on it.

CLARK ELDREDGE: A correction to the effective 16 17 dose. Dose may be adopted under this scenario. So 18 at the beginning -- and I can follow through from 19 Where it says, second paragraph, an there. 20 alternative WT may be adopted, I can say a 21 correction to the effective dose may be adopted 22 under this scenario.

23 ADAM WEAVER: Maybe you add wording in there 24 that you want it to be approved before you actually used it or, or you can't really use it after the 25
1 fact. Isn't that -- wasn't that one of your 2 objectives?

CLARK ELDREDGE: Well, one of -- well, you 3 4 can't -- for facilities that find they're in trouble 5 and they're trying to say, oh, well, yes, we were having bad practices, we're just going to put a 6 7 correction backwards on this exposure, that we don't particularly want to allow when people are adopting 8 9 it after they've gotten in trouble. 10 ADAM WEAVER: I mean, most of these facilities 11 are going to know. 12 Paragraph D. Paragraph D. JAMES FUTCH: 13 CHANTEL CORBETT: Right. That's kind of what 14 we said last meeting was the fact the majority of, 15 like hospitals especially, have been using correction factors forever and ever, but they to 16 17 find approval letter, like, that's not going to 18 happen.

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

21 CHANTEL CORBETT: Yeah.

22 CLARK ELDREDGE: We do want to make sure we get 23 it all caught up and updated and corrected but that 24 will take a couple years.

25 CHANTEL CORBETT: Right.

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1 CLARK ELDREDGE: It will be certainly nothing 2 that involves any sort of enforcement action. It 3 will just be, hey, we need to get these things 4 updated.

Right.

6 CLARK ELDREDGE: It's like we need RPPs from 7 everybody and we're still -- I've been going through 8 files and there's people supposed to file their, 9 submit RPPs to us when they're not using the 10 standard RPPs, and we hardly have any of them out 11 there.

12 CHANTEL CORBETT: Right.

13 CLARK ELDREDGE: It's just cleaning it up.

14 JOSEPH DANEK: Are you done, Adam.

CHANTEL CORBETT:

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

16 JOSEPH DANEK: My turn. I have a few comments

17 I've got.

5

JAMES FUTCH: Same one or different one? 18 19 JOSEPH DANEK: Same one. No, it's the same 20 one. Yeah, yeah. The rules are 64 E to the minus 5 21 decimal point 101. Right on the top there. Τf 22 you go to the very top. It didn't identify the 23 rules properly. 64E to the minus five point 101. 24 Right?

25 ADAM WEAVER: Yeah. Those are the definitions.

The definitions. 29 would be -- I believe we've --1 2 JOSEPH DANEK: I know that 2943. Instead of 3 161. I think it's supposed to be 159. 4 ADAM WEAVER: I don't have the definitions. 5 JOSEPH DANEK: I went through 64E minus 5 point 101. 6 ADAM WEAVER: Point 101 of the definitions? 7 JAMES FUTCH: I think, did we miss the dash 8 9 five? 10 JOSEPH DANEK: Yeah. That's what I'm getting 11 at. 12 ADAM WEAVER: Yeah, I think we did. Yeah, you 13 left the dash 5 off. 14 GEORGE GILBRIDE: If you say something about 15 differentials, I'm leaving. 16 JAMES FUTCH: I'm sitting here trying to figure 17 out -- who the hell cares about to the negative 101. 18 ADAM WEAVER: Good pick up, Joe. I didn't even 19 pick up on that one. 20 JAMES FUTCH: It's pretty small. JOSEPH DANEK: Yeah. And I'm pretty sure 161 21 22 should be 159 for weighting factor. Associated 23 with the weighting factor. 24 CLARK ELDREDGE: Yep, you know, you're right. 25 That's a typo.

1 ADAM WEAVER: It shouldn't be used here. 2 JOSEPH DANEK: Unless you want to talk about 3 [inaudible]. 4 CLARK ELDRIDGE: No, no. Although that has its 5 own interests, it's not --JOSEPH DANEK: Probably. And then this is just 6 7 an editorial. But C-2, standard setting body, standard setting body or a national or 8 9 international. You have A-N there. It's in C-2. 10 JAMES FUTCH: Over here (indicating)? 11 JOSEPH DANEK: Yeah, right there. 12 My only other comment, I don't know if you want 13 to put that in there, in the information notes. 14 Maybe not. I'm just bringing it up. Is something 15 about the dose records will be reviewed by the state during inspections. 16 I don't know 17 if you want to put that in there or not. But 18 inspect. Hopefully the inspectors will come in 19 and look at the dose records when they apply these. 20 Well, they're not waiting factors. When they alter 21 the dose, that they're going to review them to make 22 sure they properly did it. So I don't know how --23 if that should be [inaudible] 24 ADAM WEAVER: Well, usually these facilities 25 are going to use a commercial company to supply

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

JOSEPH DANEK: Oh, they're not going to do it? Oh. ADAM WEAVER: So they're going to -- they're going to tell the dosimeter company, these peoples' badges, you should write -- use this correction factor for because they're wearing aprons all the time.

JOSEPH DANEK: Okay.

9

10 CHANTEL CORBETT: The down side of that is like 11 Landauer can say sometimes that the correction is 12 there.

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

15 CHANTEL CORBETT: Yeah. Then you have some 16 problems with it later.

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

20 ADAM WEAVER: Where you guys had your own 21 dosimetry program.

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

ADAM WEAVER: Right.

25 JOSEPH DANEK: It does get inspected. This is

a different animal. But that's my only comments.
 ADAM WEAVER: Yeah. You guys probably had your
 own TLD program.

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

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

11 MARK SEDDON: Yeah, you would think, because 12 most people using electronic dosimeters are using it 13 in a fluoro environment. High exposures. We're not 14 using ours at our facilities.

15 CHANTEL CORBETT: I think Sarasota Memorial was 16 looking into trying it. I'm not sure that they have 17 yet. I can check.

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

21 ADAM WEAVER: It would be interesting. For all 22 we know, they could be self-correcting.

23 CHANTEL CORBETT: Whether it's going to be a 24 live correction or --

25 ADAM WEAVER: Yeah. Maybe it's built into

1 the --

2 CHANTEL CORBETT: Right. Can I ask you a 3 question?

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

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

11 So, what I'm trying to say are to be correct or, 12 you know, where tenses need to be corrected and word 13 agreement and stuff like that. So correct grammar 14 to match that. So that, the corrections and the 15 fact that 161 as supposed to 159.

16 ADAM WEAVER: And add the dash five.

17 CHANTEL CORBETT: I think you've got the dash.18 You need the five and the period.

19 JAMES FUTCH: That's what I was saying. Do we 20 have a 101? I'm sure we have a 101.

21 CLARK ELDREDGE: Oh. You know, it's amazing 22 how when you know what it says, you can never read 23 it.

24 CHANTEL CORBETT: Oh, yeah, your mind fills it25 in.

1 REBECCA McFADDEN: Your mind, yeah, fills it 2 in. 3 It just skips over that 4-5. ADAM WEAVER: 4 It's because you need to use four. What's the other 5 one? JAMES FUTCH: Are we done with this one? 6 7 CLARK ELDREDGE: Are we're done with this one? So would you all accept everything with that -- you 8 9 all --10 MARK SEDDON: Other than what we talked about 11 the whole summing dose for people who are badged 12 with weighting factors, do you want to say anything 13 to that? A statement that they can, some cumulative 14 annual exposure across multiple facilities, some use 15 weighting factors; some don't. 16 CLARK ELDREDGE: I mean, summing across the 17 facilities is already in the code, but you're right. 18 MARK SEDDON: Should we clarify that or not? CLARK ELDREDGE: 19 Should we clarify it? 20 ADAM WEAVER: Was it covered in this one? 21 CLARK ELDREDGE: Was it used in one and one 22 not? 23 CHANTEL CORBETT: Than what? 24 MARK SEDDON: For example, like say a physician 25 who works at two facilities, one facility is using a

1 weighting factor, one facility doesn't. 2 CHANTEL CORBETT: Right. 3 MARK SEDDON: You know, when you're summarizing 4 for the maximum permissible, can you utilize -- how 5 do you do that? That's what I'm saying. 6 CHANTEL CORBETT: Do 7 you want to say the correction factor --MARK SEDDON: The corrected dose is used for --8 9 do you need --10 CHANTEL CORBETT: Across the board? 11 MARK SEDDON: Yeah. Well, no, not across the 12 Should that be used in summing it with board. 13 the -- you're not equal, I guess what I'm trying to 14 say. 15 CHANTEL CORBETT: Yeah. 16 MARK SEDDON: So, should we clarify that? CHANTEL CORBETT: Well, I mean, it's hard not 17 18 to get those actual doses at one facility. As much 19 as you try to get three facilities to agree. But, 20 yeah. I don't know that --21 ADAM WEAVER: It's hard to imagine. 22 CHANTEL CORBETT: Because like Landauer gives 23 you the meter report, but I don't know that the 24 corrections ever show up on a meter report, to my 25 knowledge.

1 MARK SEDDON: The meter report. No. 2 ADAM WEAVER: They just report the No. 3 effective dose. 4 MARK SEDDON: Just the raw dose. 5 CHANTEL CORBETT: Right. So I don't know that there's a way unless you're the RSO for all those 6 7 facilities, like to know whether they're doing correction facilities or not in any of them. So the 8 9 meter report would be the only way to --10 ADAM WEAVER: That's why you've got to keep 11 track of them as well as you can. 12 MARK SEDDON: So maybe it's --That's the rule is that no 13 CHANTEL CORBETT: 14 matter what license you're on --15 ADAM WEAVER: You're going to have to live with 16 it until --17 CHANTEL CORBETT: Everywhere they're badged, 18 they should be combined. ADAM WEAVER: I mean, you must have a --19 20 require them to notify you that they work -- they're working for you and then they work for --21 22 MARK SEDDON: Right. 23 ADAM WEAVER: -- XYZ down the road or 24 something. 25 MARK SEDDON: Or you review the meter report

1 and they're showing up somewhere else. 2 ADAM WEAVER: Only if they're using Landauer. 3 MARK SEDDON: Only if they're using Landauer. 4 CHANTEL CORBETT: Right. 5 ADAM WEAVER: A lot of places are trying to switch because Landauer is pricey. 6 7 CHANTEL CORBETT: Yeah. It's complicated. MARK SEDDON: Okay. Well, I think -- since 8 9 this is just for a registrant to follow, then I 10 guess you don't have to worry about it since it's 11 for individuals. 12 CLARK ELDREDGE: Any concern for moving forward 13 once I do the updates? 14 JAMES FUTCH: I think you have the gavel. 15 You're the vice-chair. 16 MARK SEDDON: Oh, yes. I'm sorry. Any further 17 discussion on this? 18 (Laughter) 19 MARK SEDDON: We have a motion to approve --20 move forward with the edits suggested by Clark. 21 JOSEPH DANEK: I go forward with the motion to 22 approve. 23 MARK SEDDON: Second? 24 ADAM WEAVER: Second. 25 DR. RANDY SCHENKMAN: All in favor?

1 ALL: Aye.

2 MARK SEDDON: Any nays?

3 (No response)

4 MARK SEDDON: All right. Move forward.

5 CLARK ELDREDGE: Next.

6 ADAM WEAVER: Thank you, Clark.

7 JAMES FUTCH: Open another one of these?

8 CLARK ELDREDGE: Yeah.

9 JAMES FUTCH: Okay. Which one?

10 CLARK ELDREDGE: Either one.

ADAM WEAVER: The gonadal shield is prettystraightforward. Sign in.

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

16 ADAM WEAVER: At least we got 64.

17JOSEPH DANEK: Okay. Comments. That's the18same -- no, actually, you got a --

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

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

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

25 JOSEPH DANEK: Yeah, they probably changed it.

JAMES FUTCH: They love that stuff. 1 2 JOSEPH DANEK: 5-502. Easy correction. 3 ADAM WEAVER: This is back from 2019? 4 CHANTEL CORBETT: You're very efficient. 5 JOSEPH DANEK: Are you correcting them right there in front of us? 6 7 CLARK ELDREDGE: He's correcting there; I'm correcting here. So we'll make plenty of mistakes 8 9 when we try to combine them. 10 JAMES FUTCH: I'm not able to correct them. 11 CLARK ELDREDGE: I'm trying to -- I must have 12 done a bulk replace. Why did it repeat so many 13 times? 14 MARK SEDDON: So are there any questions or 15 comments? JOSEPH DANEK: I do, actually, because 502 ends 16 17 after diagnostic procedure. Then the sentence that 18 begins, this is only, this is the only instance, 19 that's not a part of 502. That should be a separate paragraph. Do see where that is? 20 21 CHANTEL CORBETT: Yeah. 22 JOSEPH DANEK: It almost looks like that's --23 Halfway through the CHANTEL CORBETT: 24 paragraph. 25 JOSEPH DANEK: Yeah, halfway through the

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

4 JAMES FUTCH: It should be part of this? 5 JOSEPH DANEK: Yeah. Right there where it 6 says -- right there. That's a separate paragraph. 7 REBECCA McFADDEN: New paragraph. JOSEPH DANEK: And then in the following 8 9 paragraph, it talks about the, it should be 10 Australian College of Physical Scientists. Yeah, 11 next to the last line. 12 ADAM WEAVER: Oh, yeah, what did they get 13 there? 14 REBECCA McFADDEN: Yeah. Australiation. 15 CHANTEL CORBETT: You never know. It could be 16 a thing. You never know. 17 REBECCA McFADDEN: Covering all bases. 18 JAMES FUTCH: Joining the continents together. 19 CHANTEL CORBETT: Asian, Australian.

20 CLARK ELDREDGE: It could be a pan.

21 JOSEPH DANEK: That's okay.

22 DR. NICHOLAS PLAXTON: The whole side of the 23 hemisphere. North and south. A new name.

24 CHANTEL CORBETT: Eastern --

25 REBECCA McFADDEN: It probably is. It probably

1 auto corrected it.

2 ADAM WEAVER: Cindy, did you give them that 3 name?

4 JOSEPH DANEK: Okay. A couple more. In the 5 next to the last paragraph, last sentence. It's practitioner instead of prectitioners. 6 7 ADAM WEAVER: Licensed practitioner? 8 JOSEPH DANEK: Licensed practitioner. 9 ADAM WEAVER: Not quite. 10 JAMES FUTCH: There you go. 11 JOSEPH DANEK: One more. One more in the last 12 sentence. It's Bureau of Radiation Control rather than --13 14 JAMES FUTCH: Obviously, spellcheck is 15 important. 16 JOSEPH DANEK: -- Radiaton (ph). 17 ADAM WEAVER: You can't spellcheck these 18 documents. 19 MARK SEDDON: Are there any conceptual comments 20 or discussions? 21 JOSEPH DANEK: Purely editorial. That's all I'm picking up. Actually, everything is editorial. 22 23 That's it. That's all I have. 24 MARK SEDDON: I know we discussed this at 25 previous meetings. I don't think there's any --

1 ADAM WEAVER: I think we voted on it before, 2 too, didn't we? 3 MARK SEDDON: No, we never voted on it. 4 REBECCA McFADDEN: We created it. 5 MARK SEDDON: Well, we had a discussion and we clarified this saying that we as a group, decided 6 that this was true. And then now Clark is, because 7 of the constant calls and comments probably creating 8 9 this to formalize what we had said and what the 10 Department agrees. 11 ADAM WEAVER: And what the national --12 MARK SEDDON: Matches all the national 13 organizations. 14 CHANTEL CORBETT: Right. 15 ADAM WEAVER: Yeah. Okay. 16 REBECCA McFADDEN: And now we're 17 grammatically --18 CHANTEL CORBETT: Correct. 19 REBECCA McFADDEN: -- correct. 20 MARK SEDDON: Other than the editorial 21 suggestions, are there any other comments? No? Do 22 you have a motion? 23 CHANTEL CORBETT: Motion to accept. 24 MARK SEDDON: Accept? Second? 25 REBECCA McFADDEN: Second.

1 MARK SEDDON: All in favor? 2 ALL: Aye. 3 Any nays? MARK SEDDON: 4 (No response) MARK SEDDON: No. All right. Very good. 5 Next? 6 7 ADAM WEAVER: He's taking control. Good. JAMES FUTCH: You get to see this one more 8 9 time. 10 MARK SEDDON: This is the one Clark has 11 presented to us a couple times. Was there any 12 changes from last time? 13 CLARK ELDREDGE: Yes, there was. Let me try 14 and get my copy. I can't read that that well. 15 Okay. Here it is. Actually, there wasn't any 16 significant change on this one. 17 MARK SEDDON: I didn't notice any. 18 CLARK ELDREDGE: No. Although on top of this 19 one, I am -- there are recently two things that have 20 come up, if I can remember both. The one is the 21 fact that somebody received a dose outside of the 22 therapy. They received a therapeutic dose when the 23 therapy wasn't actually thought to be running. 24 JAMES FUTCH: Was this an engineering going on 25 and someone was in the way and took the dose?

1 CLARK ELDREDGE: Yeah. It was an engineering 2 problem. It was a hardware/software failure. 3 So as far as a rule proposed language and 4 updating, expanding the definition of medical event 5 to include those cases when a dose is provided to a patient completely unintended. 6 7 MARK SEDDON: But isn't there a separate 8 regulation regarding that on exposure? 9 JAMES FUTCH: Unintended exposure? 10 MARK SEDDON: Yeah. 11 ADAM WEAVER: That would fall under unlicensed 12 practice. 13 MARK SEDDON: Maybe I'm thinking somewhere 14 else. 15 CLARK ELDREDGE: I mean, there are, but when a member of the public is exposed and things like 16 17 that. 18 MARK SEDDON: Right. 19 CLARK ELDREDGE: There are other areas of 20 exposure. It's not part of the medical event saying the medical facility, itself --21 MARK SEDDON: Right. I gotcha. 22 23 CLARK ELDREDGE: -- needs to address the issue, 24 analysis and all that. 25 ADAM WEAVER: Can you just go back up to the

2 JAMES FUTCH: Sure. Right here? 3 ADAM WEAVER: Yeah, number two. Wrong 4 individual or human research subject. 5 JAMES FUTCH: It was the right individual but --6 7 MARK SEDDON: That's the existing regulation. CLARK ELDREDGE: Yeah, that's existing. 8 9 MARK SEDDON: In quotes. 10 ADAM WEAVER: I'm just wondering why do you 11 call it research subject? 12 CHANTEL CORBETT: Because they're being 13 researched. 14 ADAM WEAVER: I mean, we don't do any research. 15 CLARK ELDREDGE: You know, you'll have to ask 16 whoever wrote that however long ago. 17 CHANTEL CORBETT: Prior to approval? 18 ADAM WEAVER: That means you have to get the 19 IRB involved. 20 CHANTEL CORBETT: Well, that's what I'm saying. 21 There's lot of those studies being done, though. 22 CLARK ELDREDGE: Yeah. I mean, this may go 23 back to cancer research treatment. 24 ADAM WEAVER: Well, external beams --25 MARK SEDDON: I think this is almost word for

word from the NRC, isn't it? Not NRC. CRCPD. 1 2 CLARK ELDREDGE: Yeah. I mean, you can 3 certainly see that, when somebody was testing out 4 IMRT or one of those new methodologies, that 5 would've been -- technically, it hadn't been approved yet, so it would've been a research subject 6 7 getting cancer treatment with a new modality. 8 CHANTEL CORBETT: Right. 9 GEORGE GILBRIDE: Well, wouldn't that work 10 with, like, also, like, human research? That's also 11 still experimental? 12 JAMES FUTCH: Human research subjects are not 13 individuals. 14 MARK SEDDON: It's experimental, but it was, 15 yeah. 16 GEORGE GILBRIDE: All right. 17 DR. NICHOLAS PLAXTON: The word subject you 18 mean? 19 ADAM WEAVER: Huh? That's why I'm wondering why do you need the -- if you're the wrong 20 individual, why do you need or human subject? Or 21 22 human research subject? 23 JAMES FUTCH: The only thing I can think of is 24 somebody objected. 25 GEORGE GILBRIDE: Okay.

1 DR. NICHOLAS PLAXTON: It does seem redundant. 2 CLARK ELDREDGE: That's why the human research 3 subject language. 4 ADAM WEAVER: It just seems very redundant. 5 Why --DR. NICHOLAS PLAXTON: Individuals would be 6 7 inclusive of human beings. CHANTEL CORBETT: Right. That includes those 8 9 other humans, right. 10 JAMES FUTCH: Maybe some lawyers got involved 11 decades ago and said no, it doesn't. 12 DR. NICHOLAS PLAXTON: Probably. 13 CHANTEL CORBETT: Yeah. Same reason CT is not 14 in the regs. 15 ADAM WEAVER: I mean, an individual would cover 16 research or medically necessary. 17 DR. NICHOLAS PLAXTON: Yeah, all the above. In 18 theory. 19 CLARK ELDREDGE: Well, we can change any 20 natural person, you know. 21 CHANTEL CORBETT: Natural. 22 GEORGE GILBRIDE: Unnatural person. 23 JAMES FUTCH: Seriously, Clark, is individual 24 defined in the regs? To only mean patients? 25 CLARK ELDREDGE: Excuse me? James, I couldn't

1 hear you.

2 JAMES FUTCH: Is individual defined narrowly in 3 the regulations some place? 4 CLARK ELDREDGE: Not that I'm aware of. 5 MARK SEDDON: Any other comments on this particular one? I know we've talked about it 6 7 before. Other than, I know you said you might be 8 making another tweak to it. 9 CLARK ELDREDGE: Well, actually, I mean, it's a 10 code standard that I need to -- it can't be in here 11 because it's not code yet. 12 MARK SEDDON: Gotcha. Very good. So do we 13 want to make a motion to move this to --14 (Adam Weaver Leaves the Meeting) 15 JAMES FUTCH: You just lost your quorum. He walked out the door. 16 17 MARK SEDDON: Yeah, that's right. 18 DR. NICHOLAS PLAXTON: We were that close. 19 MARK SEDDON: No more bathroom breaks. 20 CHANTEL CORBETT: Well, we'll table that until 21 he gets back. 22 Yeah. Once he gets back -- as we MARK SEDDON: 23 close the meeting, we'll approve. But pending a 24 return. 25 CHANTEL CORBETT: Pending Adam's approval.

1 REBECCA McFADDEN: We'll just yell at him over 2 the stall. 3 (Laughter) 4 REBECCA McFADDEN: Are you in or are you out? 5 GEORGE GILBRIDE: Okay. You go ahead. MARK SEDDON: All right. Do we want to move on 6 7 to --REBECCA McFADDEN: We need a yay or a nay. Now 8 9 he's knocking on the bathroom door. Our quorum out 10 there. 11 GEORGE GILBRIDE: Occupied. 12 JAMES FUTCH: Okay. Do you want me to do mine 13 or try to start it anyway? 14 JOSEPH DANEK: Sounds good. 15 JAMES FUTCH: Okay. So I wanted to first tell you at the last meeting, we discussed some 16 17 continuing education regulation changes to 64E-3.009. I'm not going to go back over all of 18 19 that, but those are now in process. And hopefully, in another six months, they'll actually become part 20 21 of the regulations. 22 These are the ones to change some of the 23 activities to meet the national standards. Does 24 anybody want to go over that again? No? Okay. 25 Good.

And then in terms of reports for us in our section, we're currently in the time of year where we're doing, renewals have gone out for continuing education courses and providers. We have, I think, somewhere in the neighborhood of 650 providers and 4 to 5,000 courses, depending upon the time of year that you take the number.

8 The courses that we're working on will all 9 expire at the end of January. So these are all the 10 courses that are -- that we issued three years ago.

In terms of seeing -- sticking with the subject of CE, year to date, we've audited 40 CE courses and 13 13 providers. This is not something new, but the tracking of it. And the numbers is new because of the -- trying to comply with the national standards for proceeding.

17 CHANTEL CORBETT: Question on auditing.

18 JAMES FUTCH: Sure.

19 CHANTEL CORBETT: So when auditors come to 20 audit a course, is it appropriate for them to get 21 CEUs for those talks --

JAMES FUTCH: Are you saying this has happened?
 CHANTEL CORBETT: -- as individuals? Just a
 question.

25 DR. NICHOLAS PLAXTON: That's a no.

1 JAMES FUTCH: Not typically. 2 CHANTEL CORBETT: Okay. That's kind of where 3 my mind went to, but okay. Thanks. JAMES FUTCH: Let me know -- if you know 4 5 something that's going on, let me know. CHANTEL CORBETT: 6 Okav. 7 JAMES FUTCH: Dropping back into some of the weekly stuff. We have, typically, new courses being 8 9 approved all the time. It varies from week to week 10 and year to year. Currently, for the past couple 11 weeks, it's about 40 new courses per week and that 12 may be roughly tied to people realizing, oh, look. 13 These courses need to be renewed. What about these 14 other courses? Those aren't approved. Let's submit 15 them and get them approved. Any questions on the CE aspect, continue 16 17 education aspects of it? 18 (Adam Weaver Reenters the Meeting) 19 JAMES FUTCH: Enforcement. It's always fun to 20 talk about enforcement. Currently, we have 57 complete -- currently, we have 57 cases open against 21 22 the radiologic technology profession, and those 23 involve about the same number of rad techs. We 24 also, because of being the Bureau of Radiation 25 Control and the kinds of things that the inspectors

find or that the Department in MqA come and ask us about, we have also opened cases against other practitioners. Occasionally medical physicists, occasionally physicians, and we don't keep track of the numbers of those.

6 We're supposed to have a meeting to -- we do 7 probable cause meetings probably every two months, 8 and I think the next one is a couple weeks from 9 today. And apparently, there's a couple medical 10 physicists on the agenda for that one.

11 And I think that's almost it. Putting my IT 12 hat on for a second, we're in the middle of trying 13 to convert some of our older systems to more modern 14 technologies that will allow for greater 15 functionality and features. And that is probably 16 year-long-type endeavor.

17 So that's it. Any questions?

18 CHANTEL CORBETT: It may be slightly off but 19 connected. So I know that, you know, obviously, the 20 more and more you go toward electronic capability 21 and submitting things and whatever --

JAMES FUTCH: Go to the library. They alwayshave access to web research.

24 CHANTEL CORBETT: No, no, no.

25 JAMES FUTCH: Oh, I thought this was somebody

1 that says, what if you don't have a computer? 2 CHANTEL CORBETT: No. I'm not in that field. 3 JAMES FUTCH: Where are you living? 4 CHANTEL CORBETT: The question is, are you also 5 looking to be able to accept DocuSign signatures on submissions for applications? 6 7 ADAM WEAVER: License amendments? CHANTEL CORBETT: Yeah, exactly. Because we 8 9 have a lot of remote physicians and things like that 10 these days. 11 ADAM WEAVER: Yep. 12 CHANTEL CORBETT: And not being able to send in 13 a DocuSign as a signature is becoming more and more 14 of an issue. So if that isn't part of the request 15 going forward, I would appreciate it. 16 JAMES FUTCH: I do not believe it was, but I'm 17 writing it down. 18 CHANTEL CORBETT: Add it. 19 ADAM WEAVER: It should be considered. Ι 20 second that. 21 JOSEPH DANEK: Talk about seconding things, 22 Clark, when you get back to this --DR. NICHOLAS PLAXTON: Do we have a quorum? 23 24 CHANTEL CORBETT: Oh, yeah, wait. We have a 25 quorum back. Adam is back.

1 MARK SEDDON: Adam is back, so we need to have 2 a vote. We already have a second. We need a vote 3 to approve the medical event draft notice that Clark 4 has submitted. All in favor? 5 ALL: Aye. 6 MARK SEDDON: Any nays? 7 (No Response) 8 MARK SEDDON: No nays. All right. There you 9 go. 10 Anything else, Clark? 11 CLARK ELDREDGE: I think we're good. I can 12 probably come up with more, but let's call it now. 13 MARK SEDDON: James? 14 JAMES FUTCH: Nothing. I'm done. 15 MARK SEDDON: Anyone else? 16 ADAM WEAVER: We can be here longer. 17 MARK SEDDON: All right. We're all good. 18 Meeting is adjourned. 19 CHANTEL CORBETT: Woo hoo. 20 JAMES FUTCH: And you will see some e-mails 21 from Brenda about the next meeting dates and things 22 like that. 23 April 19th. ADAM WEAVER: Thank you everybody. 24 CHANTEL CORBETT: 25 (Proceedings concluded at 2:41 p.m.)

1	CERTIFICATE OF REPORTER
2	STATE OF FLORIDA:
3	COUNTY OF ORANGE:
4	
5	I, RITA G. MEYER, RDR, CRR, CRC, do hereby certify
6	that I was authorized to and did stenographically report
7	the foregoing proceedings and that the foregoing
8	transcript is a true and correct record of my
9	stenographic notes.
10	I FURTHER CERTIFY that I am not a relative,
11	employee, attorney or counsel of any of the parties, nor
12	am I a relative or employee of any of the parties,
13	attorneys or counsel connected with the action, nor am I
14	financially interested in the outcome of the action.
15	DATED this 27th day of December, 2021.
16	Diffie chie zych day of becomber, zozi.
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18	A Aux
19	RITA G. MEYER, RDR, CRR, CRC
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