

NMSS Quarterly Newsletter



**U.S. Nuclear
Regulatory
Commission**

**Office of Nuclear
Material Safety
and Safeguards**

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REVISION TO TITLE 10, CODE OF FEDERAL REGULATIONS, (CFR) 10 CFR 35.50(d)

The U.S. Nuclear Regulatory Commission (NRC) recently corrected an inadvertent omission to the regulations in 10 CFR 35.50(d). Section 35.50 covers the training and experience (T&E) requirements for Radiation Safety Officers (RSO). Paragraphs 35.50(a) through 35.50(c) provide five separate T&E pathways for an individual seeking authorization as the RSO for a medical use license. All five pathways require an RSO preceptor attestation under 10 CFR 35.50(d). Although all five pathways are described in 10 CFR 35.50(a) through (c), 35.50(d) omitted listing 10 CFR 35.50(c)(2), the T&E pathway for already-authorized individuals, as one of the optional pathways.

In the Thursday, January 12, 2006, edition of the *Federal Register* (71 FR 1926), the NRC corrected the omission to 10 CFR 35.50(d) by adding the text, "or (c)(2)" to the listed paragraphs. This change allows the preceptor RSO to attest that the authorized individual (e.g., authorized user, authorized medical physicist or authorized nuclear pharmacist) seeking RSO status meets the requirements in 10 CFR 35.50(c)(2) (i.e., is presently an authorized user, authorized medical physicist, or authorized nuclear pharmacist identified on the licensee's license and has experience with the applicable elements of radiation safety for the types and use of byproduct material similar to those required for the RSO responsibilities). The preceptor RSO must also attest that the authorized individual has training in the radiation safety, regulatory issues and emergency procedures for the types of use for which a licensee seeks approval, and has achieved a level of radiation safety knowledge sufficient to function independently as the RSO for a medical use license. This rule change eliminates the unintended requirement for an authorized individual seeking approval as the RSO for the medical use license to also have completed the T&E requirements for one of the other four pathways in 10 CFR 35.50(a) through (c)(1).

(Contact: Cindy Flannery, Office of Nuclear Material Safety and Safeguards, 301-415-0223; e-mail: cmf@nrc.gov)

E-MAIL SUBSCRIPTION SERVICE OF THE NMSS QUARTERLY NEWSLETTER

The Office of Information Services, along with the Office of Nuclear Material Safety and Safeguards (NMSS), has implemented a Listserv program that allows external stakeholders to subscribe to, and receive, electronic copies of the NMSS Quarterly Newsletter. This newly created subscription service will allow interested parties to add their e-mail addresses to a list that will automatically send e-mailed copies of the newsletter every 3 months.

To sign up for this service, send an e-mail to: Lyris@nrc.gov

In the Subject field place: NMSS Quarterly Newsletter

In the Message/Body field add the words: subscribe nmss quarterly newsletter/user's name

Unsubscribing is the same method, except type unsubscribe in the body instead of subscribe.

Currently, each issue of the NMSS newsletter is mailed to more than 4300 individuals and organizations. By encouraging licensees to receive the NMSS newsletter as an e-mail attachment, the Agency will save substantial resources in staff hours and printing and mailing costs. Readers preferring to continue to receive a paper copy of the newsletter should contact Michael Williamson at the e-mail address and/or phone number provided below.

(Contact: Michael K. Williamson, Editor, NMSS Quarterly Newsletter, 301-415-6234, e-mail: mkw1@nrc.gov)

DECOMMISSIONING OF NUCLEAR FACILITIES WEBSITE

The quarterly update of the website will be effective June 30, 2006. The update to the website incorporates the current status of the sites undergoing decommissioning, the lessons learned, and adds to the currently existing information. The Decommissioning of Nuclear Facilities website, accessible from the U.S. Nuclear Regulatory Commission's (NRC) public home page, includes information on all decommissioning sites (complex materials, power reactors, research and test reactors, uranium recovery, and fuel cycle facilities) This site also includes maps, applicable regulations, guidance and communications, the decommissioning process, financial assurance for decommissioning, the oversight of materials and reactor sites undergoing decommissioning, and opportunities for public involvement. Users can also find decommissioning program documents, the terminated license tracking system, international aspects on decommissioning, lessons learned in decommissioning of nuclear facilities, frequently asked questions and how to contact the NRC about the decommissioning program.

(Contact: Sam Nalluswami, Division of Waste Management and Environmental Protection, 301-415-6694; e-mail: smn@nrc.gov)

NOTICE OF MEETING AND INVITATION FOR SPEAKERS

Title: Fuel Cycle Information Exchange 2006 (FCIX 2006)

The Nuclear Regulatory Commission (NRC) is hosting a seminar on August 30 and 31, 2006, to provide an opportunity for licensees, NRC staff, and other stakeholders to exchange information and discuss issues of interest pertaining to the regulation of NRC regulated fuel cycle facilities.

The seminar will be held in Rockville, Maryland, at the Universities of Maryland at the Shady Grove Campus Auditorium and will be open to the public. Fuel Cycle licensees and other interested parties were previously notified of the possibility of this meeting in a letter from Robert Pierson, dated November 28, 2005 (ADAMS accession number ML053220226). In that letter, Mr. Pierson also solicited topics of discussion and volunteer speakers for the meeting. We are expecting that NRC staff, licensees and certificate holders, and other interested parties and stakeholders will be making presentations on varying subjects of interest, with opportunity for follow-up discussion on each subject.

The proposed items of discussion are listed below; however, the NRC is seeking additional speakers to discuss topics of a broad nature, relative to the nuclear fuel cycle. If you would like an opportunity to discuss an issue, or to offer an additional topic of discussion, please contact the staff member listed below.

Currently Proposed Topics of Discussion:

- 10 CFR Part 70, Subpart H Implementation Issues
- Databases and Items Relied On For Safety (IROFS) Tracking Systems
- Boundaries of IROFS
- Impact of Increased Use of Nuclear Energy in Domestic Electricity Generation
- IAEA safety documents related to fuel cycle facilities
- 360-degree feedback from the industry and public of issues of interest pertaining to the regulation of NRC regulated fuel cycle facilities
- Overview and Experience Under the NRC's New Hearing Process By Fuel Cycle Applicants and Licensees

Location: Universities of Maryland at the
Shady Grove Campus Auditorium
9630 Gudelsky Drive
Rockville, MD 20850

Dates: August 30, 2006
9:00 am - 4:30 pm

August 31, 2006
9:00 am - 12:00 pm

(Contact: James Smith, Project Manager, Office of Nuclear Material Safety and Safeguards, Division of Fuel Cycle Safety and Safeguards, Special Projects Branch, Mail Stop: T8F42, 301-415-6459, Fax: 301-415-5370, e-mail: jas4@nrc.gov)

WELL LOGGING EVENT IN ZEALAND, DENMARK

The International Atomic Energy Agency (IAEA) reported in April 2006, that a 185-gigabecquerel (GBq) (5 Curie) Americium-241/Beryllium (Gulf Nuclear Inc. Model 71-1) sealed source was unintentionally disconnected from its holder and attached on the outside of a storage/transport container (neutron/gamma shield), where it remained unshielded for a period of 52 days.

According to the report, after a well logging operation on October 31, 2005, an operator was unable to insert a connected source and source holder into the transport/storage container. In examining the device, the operator found that the base of the source capsule was irregular and mistook it for a mounting device that had broken off from the interior of the container. He disconnected the source from the holder with his fingers and placed the empty holder in the container. The operator then attached the source to the exterior of the container with adhesive tape. On returning to his company's location, he placed the container in the storage room and reported that a mounting device had broken off from the interior of the container. The IAEA report indicates that the company management failed to react, and the unshielded source remained attached to the exterior of the container in the storage room.

Forty-eight days later, a different operator, who had been informed of the container's potentially broken mounting device, but not told to take any maintenance actions, took the container out of storage, with the unshielded source still attached on the outside, for a 4-day well logging operation. Use of the neutron probe was not planned until the end of the fourth day. However, during the 4-day period and while using various other types of non-radioactive logging probes, the operator repeatedly rested on top of the container only a few inches from the unshielded source. Apparently, from this position he could operate both the

winch and computer simultaneously, which placed him approximately 3-6 inches from the source for 8-9 hours over the 4-day logging activities. It wasn't until the neutron logging operation failed, that the operator became aware that the source was disconnected from the holder, and eventually discovered it attached to the container's exterior. The source was returned to a safe storage position in the container on December 22, 2005.

Although the operators had been instructed in neutron logging, none were familiar with the design of the source, the source holder, or the container in detail. The IAEA report indicates that neither operator was equipped with a real-time dosimeter. The first operator carried a personal dosimeter, which indicated an effective dose of 6.6 millisieverts (mSv) (660 mrem). The second operator did not carry a personal dosimeter, as required by Danish regulations. His dose was assessed from biological dosimetry, as well as log-timer readouts and distance estimates. The dose was below the lowest level of detectability (LLD) for biological dosimetry, using standard analysis of dicentric chromosomes. This is consistent with preliminary maximal dose estimates of 100-150 mSv (10,000 - 15,000 mrem). The report provides no information concerning exposures to any individuals while in storage. Further information about this event, or other events reported by the IAEA, may be found at: http://www.news.iaea.org/news/news_login.asp.

(Contact: Bruce Carrico, Office of Nuclear Material Safety and Safeguards, 301-415-7826; e-mail: jbc@nrc.gov)

NEW AUTHORIZED USER AS RSO ON NEW MEDICAL USE LICENSES

U.S. Nuclear Regulatory Commission (NRC) staff recently received an application from a physician requesting to be listed as an authorized user (AU), as well as, the Radiation Safety Officer (RSO), on a new NRC medical use license. The physician met the training and experience requirements to be recognized as an AU, but did not meet the requirements in Title 10, Code of Federal Regulations (CFR), 10 CFR 35.50(c)(2) to be listed as an RSO, since the physician had never been named as an AU on any NRC, or Agreement State medical use license. In addition, the physician did not satisfy the training and experience requirements specified in 10 CFR 35.50(a), (b), or (c)(1).

This training and experience pathway in 10 CFR 35.50(c)(2) to become an RSO requires an AU, authorized medical physicist (AMP), or authorized nuclear pharmacist (ANP) to; (1) be identified on the licensee's license; and (2) have experience with the radiation safety aspects of similar types of use of byproduct material for which the individual has Radiation Safety Officer responsibilities.

NRC revised 10 CFR 35.50 on March 30, 2005, to require any individual seeking to be recognized as an RSO to have a written attestation, signed by a preceptor Radiation Safety Officer, that the individual has satisfactorily completed specific requirements referenced in 35.50(d), and has achieved a level of radiation safety knowledge sufficient to function independently as a Radiation Safety Officer for a medical use licensee (60 Federal Register (FR) 16336, March 30, 2005). Prior to this revision, the requirements that are now in 10 CFR 35.50(c)(2), did not require such an attestation. Note that on January 12, 2006, NRC corrected an inadvertent omission in paragraph (d) to make it clear that an AU, AMP, or ANP meeting the requirements in paragraph (c)(2), does not have to meet the health physicist/medical physicist requirements in the other training and experience pathways. However, the preceptor must still attest that the individual meets the requirements specified in paragraphs (c)(2), and (d) (71 FR 1926, January 12, 2006).

Although the physician applying to be both a new AU and RSO had experience with the radiation safety aspects of similar types of use of byproduct material for which the individual would have Radiation Safety Officer responsibilities, the physician could not meet the other requirement in 10 CFR 35.50 (c)(2), because the individual was not yet an AU. In addition, a preceptor RSO could not attest that the person was either an AU, or met the training and experience requirements, in any of the other pathways specified in 10 CFR 35.50. The applicant was requested to identify another individual as the RSO, and provide documentation that the person met the requirements in 10 CFR 35.50. Applicants for new licenses should be aware of the current requirements.

(Contact: Donna-Beth Howe, Office of Nuclear Material Safety and Safeguards, 301-415-7848; e-mail: dbh@nrc.gov)

GENERIC COMMUNICATIONS ISSUED (March 1, 2006 - May 31, 2006)

The following are summaries of U.S. Nuclear Regulatory Commission (NRC) generic communications. If one of these documents appears relevant to your needs and you have not received it, please call one of the technical contacts listed below. The Internet address for the NRC library of generic communications is - <http://www.nrc.gov/readingrm/doccollections/gencomm/index.html>. Please note that this address is case-sensitive and must be entered exactly as shown. If you have any questions or comments about generic communications in general, please contact Angela R. McIntosh, (301) 415-5030, or by e-mail: arm@nrc.gov.

Bulletins (BLs)

None.

Generic Letters (GLs)

None.

Information Notices (INs)

IN 2006-07, “Inappropriate Use of a Single-Parameter Limit,” as a Nuclear Criticality Safety Limit,” was issued on March 31, 2006. This IN was issued to all licensees authorized to possess a critical mass of special nuclear material.

(Technical contact: Tamara D. Powell, NMSS, 301-415-5095; email: tdp@nrc.gov)

IN 2006-10, “Use of Concentration Control for Criticality Safety,” was issued on April 23, 2006. This IN was issued to all licensees authorized to possess a critical mass of special nuclear material.

(Technical contact: Natreon Jordan, NMSS, 301-415-7648; e-mail: njj@nrc.gov)

Regulatory Issue Summaries (RIS’)

RIS 2006-05, “Withdrawal of Transportation Safeguards Advisories SA-01-01, Rev. 1 and SA-03-02,” was issued on April 20, 2006. This RIS was issued to licensees that transport, or deliver to a carrier for transport, radioactive material in quantities of concern.

(Technical contacts: Oleg Bukharin, NSIR, 301-415-3551; e-mail oab@nrc.gov; and Adelaide Giantelli, NSIR, 301-415-3521; e-mail: asg2@nrc.gov)

(General Contact: Angela R. McIntosh, NMSS, 301-415-5030; e-mail: arm@nrc.gov)

SIGNIFICANT EVENTS (March 1, 2006 - April 30, 2006)

Event #1: Overexposure to Radiographers

Date and Place: March 3, 2006, North Kensington, Rhode Island

Nature and Probable Causes: The licensee reported that two radiographers received radiation overexposures. A radiography trainer and trainee were traversing from one cell to another at a fixed radiography facility. They entered a cell, without a survey meter, to view the radiography setup and check out the guide tube and other components.

The trainer and trainee were in close proximity to the partially collimated source tip, unaware that the source was exposed. Both persons handled the source during the training experience. A third radiographer, who was actually performing the radiography in the cell, became aware that the source was exposed and advised the other two radiographers. All three exited the cell, secured the source, and notified the radiation safety officer. The incident involved an AEA Technologies exposure device (Model 660-B, Serial #B1302) with an Iridium -192 (Ir-192) source (Model 424-9, Serial #27093B) containing an activity of 3.44 terabecquerel (93 curies). A re-enactment was performed to determine the time line for involvement in the cell and actual handling of the source. The radiographer trainer and trainee were estimated to have handled the source 15 to 20 seconds, which resulted in estimated maximum doses of 4.889 centisieverts (rem) whole-body deep dose; 4.889 centisieverts (rem) lens of the eye dose, and 4.643 centisieverts (rem) shallow dose. Extremity doses to the trainer and trainee range from 1000 to 18,450 centigray (rad). The third radiographer's estimated whole-body dose was 3.95 millisieverts (395 mrem) Investigation is ongoing with the assistance of the NRC staff. The licensee also solicited the assistance of dose recreation and assessment from a private physicist and the provider of the radiography source. The licensee has suspended the use of radioactive material until the investigation is complete.

Event #2: Brachytherapy Overdose Event

Date and Place: April 11, 2006, Clarksburg, West Virginia

Nature and Probable Causes: The licensee reported that two female patients received brachytherapy high-dose-rate treatment doses more than 50 percent greater than the prescribed dose. Each patient was to receive a total dose of 3000 centigray (cGy) (rad), distributed during six treatments of 500 cGy (rad) each. The treatments involved the insertion of a 162.8 gigabecquerel (4.4 curie) Ir-192 source into the cervical area. During the first treatment, the first patient received 1040 cGy (rad) on April 11, 2006, and the second patient received 1058 cGy (rad) on April 18, 2006. The attending physician is going to alter the remaining treatments to 350 cGy (rad) for each patient to keep the total dose to the prescribed 3000 cGy (rad). The cause of the medical events was human error. The operator did not check the magnification reading on the computer before administering the dose to each patient. The referring physician discussed the error with each patient when they came in for their next treatments on April 21, 2006.

(Contact: Angela R. McIntosh, NMSS, 301-415-5030; e-mail: arm@nrc.gov)

SIGNIFICANT ENFORCEMENT ACTIONS

The U.S. Nuclear Regulatory Commission's (NRC's) enforcement program can be accessed via the NRC's homepage [<http://www.nrc.gov/>] under "What We Do." Documents related to cases can be accessed at [<http://www.nrc.gov/>], "Electronic Reading Room," "Documents in ADAMS." ADAMS is the Agency-wide Document Access and Management System. Help in using ADAMS is available from the NRC Public Document Room, telephone: 301-415-4737 or 1-800-397-4209

Washington Hospital Center (EA-06-029)

On May 4, 2006, a Notice of Violation was issued for a Severity Level III violation involving deliberate failure to secure, from unauthorized removal, and failure to maintain constant surveillance over licensed material. Specifically, the lock on the door to the hot lab, a controlled area containing licensed material, had been deliberately disabled with tape, to allow ease of access, and the hot lab was left unattended, with the door lock disabled.

Epsilon Products Company (EA-06-026)

On May 3, 2006, a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$16,250 was issued for a Severity Level III problem composed of six violations of NRC requirements involving the licensee's failure to conduct operations such that the dose in an unrestricted area, from external sources, exceeded regulatory limits. The most significant of these violations involved the radiation exposure of five employees and contractors, who were not radiation workers (and therefore considered members of the public), who received radiation doses in excess of the regulatory limit of 0.001 Sievert (Sv) (100 millirem) in a year, i.e., they received estimated doses ranging from 0.00103 Sv (103 millirem) to 0.00197 Sv (197 millirem).

H&G Inspection Company, Inc. (EA-06-021)

On May 1, 2006, a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$6500 was issued for a Severity Level III violation involving a willful failure to block and brace a radiographic exposure device during transport to and from a temporary jobsite. Two additional violations, not assessed a civil penalty, were identified. These involved failure to control and maintain constant surveillance of licensed material in an unrestricted area, and failure to have a second qualified individual observe radiographic operations. Because these violations were unrelated, each was separately categorized as Severity Level III.

GEO EXPLOR, Inc. (EA-06-017)

On April 17, 2006, a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$3250 was issued for a Severity Level III problem involving three violations. The violations occurred as a result of the

authorized user's failure to: (1) control and maintain constant surveillance of a licensed gauge; (2) use two independent physical controls to form a tangible barrier to secure the gauge against unauthorized removal; and (3) properly block and brace the gauge during transport. Specifically, the authorized user failed to adequately lock a transport case onto the bed of his truck and close the tailgate. As a result, the case containing a licensed gauge fell off the truck and was in the public domain for approximately 6 days before it was recovered.

MISTRAS Holdings Group (EA 05-238; EA-06-065; and EA-06-066)

On April 6, 2006, a Notice of Violation and Proposed Imposition of Civil Penalties in the amount of \$19,500, was issued for three Severity Level III problems associated with violations of NRC requirements. The first Severity Level III problem involved the licensee's failure, after performing radiographic operations, to: (1) survey the radiographic exposure device and guide tube to determine that the sealed source had been returned to its shielded position, before dismantling the equipment; and (2) secure the sealed source in the shielded position after the source was returned to the shielded position. The second Severity Level III problem involved the licensee's failure, at a field location, to: (1) have two qualified individuals present when a radiographic exposure was being performed; and (2) have a qualified individual directly observe the radiographic assistant perform radiographic operations. The third Severity Level III problem involved: (1) the licensee's failure to control and maintain constant surveillance of licensed material that is in a controlled or unrestricted room and that is not in storage; and (2) the licensee's failure to immediately report to the NRC missing licensed material, Iridium-192, in a radiographic exposure device (i.e., licensed material in an aggregate quantity greater than 1000 times the quantity specified in 10 CFR Part 20, Appendix C), that could result in an exposure to persons in an unrestricted area. A base civil penalty in the amount of \$6500 was imposed for each of the three problems, resulting in a civil penalty of \$19,500.

Bayou Inspection Services, Inc. (EA-05-137)

On March 17, 2006, a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$6000 was issued for a Severity Level III violation. The violation involved two separate instances of the failure to secure or maintain constant surveillance of licensed material (radiographic exposure devices) in unrestricted areas. In addition, the NRC determined that willfulness was associated with one instance of this violation.

Thomas Jefferson University Hospital (EA-05-237)

On March 3, 2006, a Notice of Violation was issued for a Severity Level III violation involving the failure to control the annual occupational shallow dose equivalent to 0.5 sieverts (50 rem), and the failure to conduct adequate

surveys. Specifically, a nuclear medicine technologist (NMT) received an exposure to the skin of the right thumb when it became contaminated with sodium iodide (iodine-131), during treatment of a patient. The NMT did not perform adequate surveys necessary for the timely identification of skin contamination and assessment of dose to the skin of her right thumb. As a result, the NMT's skin was contaminated for 26 hours before being detected.

Star-Lite Global, Inc. (EA-05-174)

On February 28, 2006, a Notice of Violation and Exercise of Enforcement Discretion was issued for a Severity Level III violation involving the failure to obtain an exempt distribution license, as required by 10 CFR 30.15, before transferring specialty light bulbs containing radioactive material, Krypton -85 (Kr-85). Based on the facts that Star-Lite Global stopped importing and distributing the Kr-85 bulbs by the fall of 2003, no longer operates nor conducts transactions, plans to file for bankruptcy, and the low safety significance of the Kr-85 bulbs that it distributed, NRC is exercising discretion to refrain from issuing a civil penalty in this case.

(General Contact: Sally Merchant, Office of Enforcement, 301-415-2747; e-mail: slm2@nrc.gov)

SELECTED FEDERAL REGISTER NOTICES (March 1, 2006 – May 31, 2006)

“Abnormal Occurrence Reports: Implementation of Section 208 of the Energy Reorganization Act of 1974; Revised Policy Statement,” 71 FR 10568, March 1, 2006.

(Contact: Sheryl Burrows, Office of Nuclear Regulatory Research, 301-415- 6086; e-mail: sab2@nrc.gov, Mail Stop: T9-F31)

10 CFR Part 72 [RIN 3150-AH87] “List of Approved Spent Fuel Storage Casks: VSC-24 Revision 6,” 71 FR 14120, March 21, 2006.

(Contact: Jayne M. McCausland, Office of Nuclear Material Safety and Safeguards, 301-415-6219; e-mail: jmm2@nrc.gov)

“State of Minnesota: Discontinuance of Certain Commission Regulatory Authority Within the State; Notice of Agreement Between the NRC and the State of Minnesota,” 71 FR 14965, March 24, 2006.

(Contact: Aaron T. McCraw, Office of State and Tribal Programs, 301-415-1277; e-mail: atm@nrc.gov)

10 CFR Part 110 [RIN 3150-AH89] "Revision of NRC Form 7, Application for NRC Export/Import License, Amendment, or Renewal," 71 FR 19102, April 13, 2006.

(Contact: Brooke G. Smith, Office of International Programs, 301-415-2347; e-mail: bgs@nrc.gov)

10 CFR Part 72 [RIN 3150-AH86] "List of Approved Spent Fuel Storage Casks: FuelSolutions TM Cask System, Revision 4," 71 FR 19831, April 18, 2006.

(Contact: Jayne M. McCausland, Office of Nuclear Material Safety and Safeguards; 301-415-6219, e-mail: jmm2@nrc.gov)

NRC Enforcement Policy: "Extension of Discretion Period of Interim Enforcement Policy," 71 FR 19905, April 18, 2006.

(Contact: Michael Johnson, Office of Enforcement, 301-415-2741; e-mail: mrj1@nrc.gov)

10 CFR Part 110 [RIN 3150-AH88] "Implementation of the Nuclear Export and Import Provisions of the Energy Policy Act of 2005," 71 FR 20336, April 20, 2006.

(Contact: Brooke G. Smith, Office of International Programs, 301-415-2347; e-mail: bgs@nrc.gov)

"Report to Congress on Abnormal Occurrences; Fiscal Year 2005; Dissemination of Information," 71 FR 26393, May 4, 2006.

(Contact: None listed)

"Notice of Availability of Draft Standard Review Plan for Activities Related to U.S. Department of Energy Waste Determinations", NUREG-1854, 71 FR 30967, May 31, 2006.

(Contact: Anna Hajduk Bradford, Division of Waste Management and Environmental Protection, 301-415-5228; fax 301-415-5397; e-mail: ahb1@nrc.gov)

(General Contact: Michael K. Williamson, Office of Nuclear Material Safety and Safeguards, 301-415-6234, e-mail: mkw1@nrc.gov)

NOTE TO READERS: In an effort to keep the NMSS Quarterly Newsletter relevant, useful, and informative, feedback regarding the content of the newsletter is welcome. Readers desiring to contribute articles, self-explanatory diagrams, suggestions for future articles, bulletins, web-site postings, and other items of interest to the NMSS Quarterly Newsletter readership, should contact Michael K. Williamson, from the Office of Nuclear Material Safety and Safeguards, Rulemaking and Guidance Branch. Mr. Williamson may be contacted at (301)415-6234 or mkw1@nrc.gov. In addition, to ensure proper delivery and non-interruption of subscription service, please report any address changes, additions, or deletions to Mr. Williamson.

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