unnecessary regulatory burden related to SSCs of low safety significance by removing such SSCs from the scope of special treatment requirements. The Commission subsequently approved the NRC staff's rulemaking plan and issuance of an Advanced Notice of Proposed Rulemaking (ANPR) as outlined in SECY–99–256, ''Rulemaking Plan for Risk-Informing Special Treatment Requirements,'' dated October 29, 1999.

The Commission published the ANPR in the **Federal Register** (65 FR 11488) on March 3, 2000, and subsequently published a proposed rule for public comment (68 FR 26511) on May 16, 2003. Then, on November 22, 2004, the Commission adopted a new section, referred to as § 50.69, within Title 10, part 50, of the *Code of Federal Regulations,* on risk-informed categorization and treatment of SSCs for nuclear power plants (69 FR 68008).

The NRC issued a draft of this guide, Draft Regulatory Guide DG–1121, for public review and comment as part of the § 50.69 rulemaking package in May 2003. The staff subsequently received and addressed public comments in developing the previous revision of this guide, which the agency published in January 2006, and has since incorporated additional stakeholder comments in preparing the current revision. However, since this is a new regulatory approach to categorizing SSCs, and to ensure that the final guidance adequately addresses lessons learned from the initial applications, the NRC decided to issue this guide for trial use. Therefore, this trial regulatory guide does not establish any final staff positions for purposes of the Backfit Rule, 10 CFR 50.109, and may continue to be revised in response to experience with its use. As such, any changes to this trial guide prior to staff adoption in final form will not be considered to be backfits as defined in 10 CFR 50.109(a)(1). This will ensure that the final regulatory guide adequately addresses lessons learned from regulatory review of pilot and follow-on applications, and that the guidance is sufficient to enhance regulatory stability in the review, approval, and implementation of probabilistic risk assessments (PRAs) and their results in the risk-informed categorization process required by § 50.69.

The NRC staff encourages and welcomes comments and suggestions in connection with improvements to published regulatory guides, as well as items for inclusion in regulatory guides that are currently being developed. You may submit comments by any of the following methods.

Mail comments to: Rules and Directives Branch, Office of Administration, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001.

Hand-deliver comments to: Rules and Directives Branch, Office of Administration, U.S. Nuclear Regulatory Commission, 11555 Rockville Pike, Rockville, Maryland 20852, between 7:30 a.m. and 4:15 p.m. on Federal workdays.

Fax comments to: Rules and Directives Branch, Office of Administration, U.S. Nuclear Regulatory Commission, at (301) 415–5144.

Requests for technical information about Revision 1 of Regulatory Guide 1.201 may be directed to Donald G. Harrison at (301) 415–3587 or via e-mail to *DGH@nrc.gov.*

Regulatory guides are available for inspection or downloading through the NRC's public Web site in the Regulatory Guides document collection of the NRC's Electronic Reading Room at *http://www.nrc.gov/reading-rm/doc-collections.* Electronic copies of Revision 1 of Regulatory Guide 1.201 are also available in the NRC's Agencywide Documents Access and Management System (ADAMS) at *http://www.nrc.gov/reading-rm/adams.html,* under Accession #ML061090627.

In addition, regulatory guides are available for inspection at the NRC's Public Document Room (PDR), which is located at 11555 Rockville Pike, Rockville, Maryland; the PDR's mailing address is USNRC PDR, Washington, DC 20555–0001. The PDR can also be reached by telephone at (301) 415–4737 or (800) 397–4205, by fax at (301) 415–3548, and by e-mail to *PDR@nrc.gov.* Requests for single copies of draft or final guides (which may be reproduced) or for placement on an automatic distribution list for single copies of future draft guides in specific divisions should be made in writing to the U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, Attention: Reproduction and Distribution Services Section; by e-mail to *DISTRIBUTION@nrc.gov;* or by fax to (301) 415–2289. Telephone requests cannot be accommodated.

Regulatory guides are not copyrighted, and Commission approval is not required to reproduce them.

Authority: 5 U.S.C. 552(a).

Dated at Rockville, Maryland, this 1st day of May, 2006.

For the U.S. Nuclear Regulatory Commission.

Brian W. Sheron,

Director, Office of Nuclear Regulatory Research.

[FR Doc. E6–6747 Filed 5–3–06; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

Report to Congress on Abnormal Occurrences; Fiscal Year 2005; Dissemination Of Information

Section 208 of the Energy Reorganization Act of 1974 (Pub. L. 93–438) defines an abnormal occurrence (AO) as an unscheduled incident or event which the U.S. Nuclear Regulatory Commission (NRC) determines to be significant from the standpoint of public health or safety. The Federal Reports Elimination and Sunset Act of 1995 (Pub. L. 104–66) requires that AOs be reported to Congress annually. During fiscal year 2005, 9 events that occurred at facilities licensed or otherwise regulated by the NRC and/or Agreements States were determined to be AOs. The report describes three events at facilities licensed by the NRC. All three events occurred at medical institutions. The first event involved a patient who received the incorrect dose distribution while undergoing therapeutic brachytherapy [1] treatment. The second event involved an infant who was administered the incorrect diagnostic dosage of technetium-99m. The third event involved three patients who received unintended radiation doses to the skin of their thighs while undergoing therapeutic treatment. The report also addresses 6 AOs at facilities licensed by Agreement States. [Agreement States are those States that have entered into formal agreements with the NRC pursuant to section 274 of the Atomic Energy Act (AEA) to regulate certain quantities of AEA licensed material at facilities located within their borders.] Currently, there are 34 Agreement States. During Fiscal Year 2005, Agreement States reported six events that occurred at Agreement State-licensed facilities, including five therapeutic medical events and one diagnostic medical event. All six events met the criteria for AO categorization. As required by section 208, the

[1] Brachytherapy means a method of radiation therapy in which sources are used to deliver a radiation dose at a distance of up to a few centimeters by placement of sources on the body surface, in natural body cavities, or by placement directly in tissues.

discussion for each event includes the date and place, the nature and probable consequences, the cause or causes, and the action taken to prevent recurrence. Each event is also being described in NUREG–0090, Vol. 28, ''Report to Congress on Abnormal Occurrences, Fiscal Year 2005.'' This report will be available electronically at the NRC Web site *http://www.nrc.gov/reading-rm/doc-collections/nuregs/staff/*.

Nuclear Power Plants

During this period, no events at U.S. nuclear power plants were significant enough to be reported as AOs.

Fuel Cycle Facilities (Other Than Nuclear Power Plants)

During this period, no events at U.S. fuel cycle facilities were significant enough to be reported as AOs.

Other NRC Licensees (Industrial Radiographers, Medical Institutions, etc.)

During this reporting period, three events at NRC-licensed or regulated facilities were significant enough to be reported as AOs.

05–01 Medical Event at the University of Minnesota in Minneapolis, Minnesota

Criterion IV, ''For Medical Licensees,'' of Appendix A to this report states, in part, that a medical event that results in a dose that is (1) equal to or greater than 1 Gy (100 rads) to a major portion of the bone marrow, to the lens of the eye, or to the gonads or (2) equal to or greater than 10 Gy (1,000 rads) to any other organ; and represents a prescribed dose or dosage that is delivered to the wrong treatment site will be considered for reporting as an AO.

Date and Place—January 24, 2005, Minneapolis, Minnesota.

Nature and Probable Consequences—The licensee reported that a patient being treated for cervical cancer received an incorrect dose distribution. One area of the cervix received 8.21 Gy (821 rads) instead of the intended 16.43 Gy (1,643 rads). Another area of the cervix received 3.72 Gy (372 rads) instead of the intended 4.65 Gy (465 rads). Additionally, other locations received higher than intended doses. The intended doses to the bladder and the rectum were 11.47 Gy (1,147 rads) each, but they received 14.48 Gy (1,448 rads) and 20.12 Gy (2,012 rads), respectively. The treatment involved an applicator with an insert which contained low-dose radiotherapy sources. The licensee cut the insert 6 centimeters (cm) too short so that when the applicator was positioned in the patient's cervix, the three cesium-137 (Cs-137) sources were not extended the proper distance. The referring physician and patient were informed of this event. The licensee does not believe that this event will have any adverse health effects on the patient. The patient subsequently received a follow-up treatment to deliver the full intended dose to the treatment sites.

Cause(s)—This event was caused by human error. The incorrect dose was administered to the incorrect location.

Actions Taken to Prevent Recurrence—Corrective actions taken by the licensee included stopping all low dose-rate treatments until all individuals are trained, and modifying their procedures to incorporate a dual verification system.

This event is closed for the purpose of this report.

05–02 Medical Event at St. Johns Mercy Hospital in St. Louis, Missouri

Criterion I.A.2, ''For All Licensees,'' of Appendix A to this report states, ''Any unintended radiation exposure to any minor (an individual less than 18 years of age) resulting in an annual total effective dose equivalent (TEDE) of 50 millisieverts (mSv) (5 rem) or more, or to an embryo/fetus resulting in a dose equivalent of 50 mSv (5 rem) or more,'' will be considered for reporting as an AO.

Date and Place—March 9, 2005, St. Louis, Missouri.

Nature and Probable Consequences—The licensee reported that a 5-month old infant was prescribed 18.5 MBq (0.5 mCi) of technetium-99 metastable (Tc-99m), but instead received 414.4 MBq (11.2 mCi) of Tc-99m. Hospital personnel did not look at the dosage label to verify the dose to be administered. The whole body dose to the infant was calculated to be between 0.052 to 0.10 Sv (5.2 to 10 rem). The physician informed the infant's parents. The NRC's medical consultant determined that there were no acute or subacute effects noted in the patient, but recommended that a pediatric gastroenterologist monitor the patient for cancer for an extended period of time.

Cause(s)—The event was caused by human error. The hospital staff member did not look at the dosage label before administering the radiopharmaceutical.

Actions Taken to Prevent Recurrence—Corrective actions taken by the licensee involved revision of their procedures to require dual verification of all dosages to be administered to children and retraining the staff on the new procedures.

This event is closed for the purpose of this report.

05–03 Medical Event at St. Joseph Regional Medical Center in South Bend, Indiana

Criterion IV, ''For Medical Licensees,'' of Appendix A to this report states, in part, that a medical event that results in a dose that is (1) equal to or greater than 1 Gy (100 rads) to a major portion of the bone marrow, to the lens of the eye, or to the gonads or (2) equal to or greater than 10 Gy (1,000 rads) to any other organ; and represents a prescribed dose or dosage that is delivered to the wrong treatment site will be considered for reporting as an AO.

Date and Place—Between January 26 and March 22, 2004 (reported March 25, 2005 due to a misinterpretation of reporting requirements by the licensee), South Bend, Indiana.

Nature and Probable Consequences—The licensee reported in March and April 2005, that between January 26 and March 22, 2004, three patients received unintended radiation doses to the skin of their thighs from cesium-137 brachytherapy sources. The vaginal applicator used for the treatments was loaded with incorrectly sized cesium-137 sources, which migrated from the intended treatment position through the placement spring when the patient moved to a more up-right position. As a result of the sources moving, the patient's inner thighs received unintended doses of radiation. Approximately two weeks after treatment, the patients developed skin lesions on their inner thighs. The licensee determined that these patients received unintended doses to a small area of the skin on the upper thigh of approximately 2000, 1500, and 2000 cGy (rad), respectively. Based on clinical observations, the licensee determined that all patients received the respective prescribed doses to the intended treatment areas. The referring physician and patients were notified of the event. The licensee referred the patients to other institutions and care providers for specialized followup wound care to treat the recurring skin ulcerations. The NRC retained a medical consultant during the inspection associated with the event. The long-term health effects on the patients, as a result of the unintended doses, is unknown.

Cause(s)—The causes of these events were improper source selection, inadequate manufacturer instructions, inadequate management oversight, and inadequate procedures.

Actions Taken to Prevent Recurrence—Corrective actions taken by the licensee involved modifying the applicator by using different hardware to hold the sources in place, revising

their procedures, and retraining the staff on the new procedures.

This event is closed for the purpose of this report.

Agreement State Licensees

During this reporting period, six events at Agreement State-licensed facilities were significant enough to be reported as AOs.

AS 05–01 Iridium-192 Brachytherapy Seed Medical Event at LDS Hospital in Salt Lake City, Utah

Criterion IV, ''For Medical Licensees,'' of Appendix A to this report states, in part, that a medical event that results in a dose that is (1) equal to or greater than 1 Gy (100 rads) to a major portion of the bone marrow, to the lens of the eye, or the gonads, or (2) equal to or greater than 10 Gy (1,000 rads) to any other organ; and represents a prescribed dose or dosage that is delivered to the wrong treatment site, will be considered for reporting as an AO.

Date and Place—October 26, 2004; LDS Hospital; Salt Lake City, Utah.

Nature and Probable Consequences—A patient received 27.56 Gy (2,756 rads) instead of the prescribed 5 Gy (500 rads) during a high dose-rate (HDR) treatment for larynx cancer. The event involved an iridium-192 (Ir-192) source with an activity of 244.2 GBq (6.6 Ci). The error was caused by the use of the diameter instead of the radius of a circular tool to mark the treatment site in a computer software program. As a result, the area treated was 2 centimeters (cm) away from the intended treatment site. The error was discovered before the third fraction. The prescribing physician stopped the treatment until dosimetry information was completed. The licensee notified the patient and the patient's referring physician of the event. The licensee determined that the impact of the additional dose is probable acute radiation effects and possible late or chronic toxicities.

Cause(s)—This event was caused by human error. The incorrect size button corresponding to the circle tool was used, which caused the diameter instead of the radius to be used in the dosing plan. This caused the incorrect dose to be administered to the incorrect location.

Actions Taken To Prevent Recurrence

Licensee—The licensee suggested that the software manufacturer print the word ''RADIUS'' on the ''size'' button located adjacent to the circle tool. To date, the manufacturer has not responded to this issue. The licensee will measure the distance on the brachytherapy device's hard copy output with a ruler to confirm that the distance is entered correctly. The licensee also modified the HDR dose check program so that, in addition to confirming the doses to coordinates entered into the device's input, user specified point coordinates may be manually entered into the check program and compared to what is calculated.

State Agency—The Utah Division of Radiation Control investigated the event on November 3, 2004 and approved the corrective actions that the licensee implemented to prevent the recurrence.

This event is closed for the purpose of this report.

AS 05–02 Diagnostic Medical Event at Baystate Health Systems in Springfield, Massachusetts

Criterion IV, ''For Medical Licensees,'' of Appendix A to this report states, in part, that a medical event that results in a dose that is (1) equal to or greater than 1 Gy (100 rads) to a major portion of the bone marrow, to the lens of the eye, or the gonads, or (2) equal to or greater than 10 Gy (1,000 rads) to any other organ; and represents a prescribed dose or dosage that is delivered by the wrong treatment mode, will be considered for reporting as an AO.

Date and Place—January 7, 2005; Baystate Health Systems; Springfield, Massachusetts.

Nature and Probable Consequences—The licensee reported that a patient should have received 0.63 MBq (0.017 mCi) of iodine-131 (I-131) for a thyroid uptake study but instead received 133.2 MBq (3.6 mCi) of I-131 for a total body scan. A nuclear medicine technologist incorrectly placed the order for a total body scan instead of a thyroid uptake study without looking at the diagnosis. The I-131 was administered and it was later discovered that the wrong procedure was administered. The administration resulted in a thyroid dose of 131 Gy (13,100 rads). The patient and referring physician were notified of the error. The licensee indicated there would be no negative health effects from this administration because the patient had hyperthyroidism, thus, the unintended thyroid dose will be taken into account when additional I-131 is given to the patient.

Cause(s)—Human error in that the procedure was erroneously posted as a total body scan when it was actually a thyroid uptake study. This caused the wrong quantity of I-131 to be administered.

Actions Taken To Prevent Recurrence

Licensee—Corrective actions taken by the licensee involved modifying procedures to include removing Central Booking from radioisotope ordering (the referring physician will fax the order directly to Nuclear Medicine), switching from I-131 to I-123 for thyroid uptake studies, and revising the nuclear medicine request form for thyroid procedures.

State Agency—The State reviewed and approved the corrective actions taken by the licensee and will follow-up at the next inspection.

This event is closed for the purpose of this report.

AS 05–03 High Dose-Rate Afterloader Medical Event at Saddleback Memorial Medical Center in Laguna Hills, California

Criterion IV, ''For Medical Licensees,'' of Appendix A to this report states, in part, that a medical event that results in a dose that is (1) equal to or greater than 1 Gy (100 rads) to a major portion of the bone marrow, to the lens of the eye, or the gonads, or (2) equal to or greater than 10 Gy (1,000 rads) to any other organ; and represents a prescribed dose or dosage that is delivered to the wrong treatment site will be considered for reporting as an AO.

Date and Place—January 24–28, 2005; Saddleback Memorial Medical Center; Laguna Hills, California.

Nature and Probable Consequences—A patient undergoing therapeutic radiation treatment following a breast lumpectomy was treated with a high dose-rate (HDR) device using an iridium-192 (Ir-192) source with an activity of 277.5 GBq (7.5 Ci). The prescribed dose was 35 Gy (3,500 rads) to the inside of the breast at the site of the excised tumor, but instead the patient received 70 Gy (7,000 rads) to other portions of the breast during treatment. The unintended irradiation occurred when the HDR device was mispositioned. Re-evaluation of the treatment plan revealed that the wrong source wire travel distance was used during the treatment. The Ir-192 source was positioned 8 centimeters (cm) short of the planned location. The licensee believes the error occurred when the source wire travel distance was input to the HDR device; however, since no record was maintained of the source wire travel distance measured by the therapy technologist, this could not be verified. It is known that the incorrect distance was input to the HDR planning system. The patient and the referring physician were notified of the event. No long-term health effects are expected due to the unplanned tissue dose.

Cause(s)—This event was attributed to human error and an inadequate procedure.

Actions Taken to Prevent Recurrence

Licensee—A procedure was developed specifying the need to verify and document the verification of source wire travel distance determination and training on the correct input to the treatment planning system was performed. In addition, nominal source wire travel distances for expected types of HDR usage were added to the form utilized for recording the HDR treatment quality assurance checklist, thus providing a check on the determination of this parameter.

State Agency—State inspectors investigated the medical event and issued written violations for failure to follow a license condition that required independent verification of HDR treatment data input, and for failure to report the medical event to the state within 24 hours of its discovery. The State reviewed the licensee's corrective actions and found them adequate to prevent recurrence.

This event is closed for the purpose of this report.

AS 05–04 Yttrium-90 Therapeutic Medical Event at University of Wisconsin in Madison, Wisconsin

Criterion IV, ''For Medical Licensees,'' of Appendix A to this report states, in part, that a medical event that results in a dose that is (1) equal to or greater than 1 Gy (100 rads) to a major portion of the bone marrow, to the lens of the eye, or the gonads, or (2) equal to or greater than 10 Gy (1,000 rads) to any other organ; and represents a prescribed dose or dosage that is delivered to the wrong treatment site will be considered for reporting as an AO.

Date and Place—April 5, 2005; University of Wisconsin in Madison; Madison, Wisconsin.

Nature and Probable Consequences—A patient was administered a 1.78 GBq (48 mCi) dose of yttrium-90 (Y-90), instead of the intended 1.04 GBq (28 mCi) Y-90 dose. As a result of the medical event, the patient received a dose of 1.07 to 3.20 Gy (107 to 320 rads) to the red bone marrow, with a median exposure of 2.31 Gy (231 rads) from Y-90. The error was discovered on April 7, 2005, during a licensee review of records. The patient and referring physician were notified of the event. The licensee indicated there will be no negative health effects from this administration.

Cause(s)—Lack of management oversight which attributed to failure to prepare a written directive prior to the administration, a poor training program, and human error.

Actions Taken to Prevent Recurrence

Licensee—The licensee suspended the use of Y-90 and conducted a root cause investigation of the event. The licensee's corrective actions included writing new policies and procedures, implementing new training programs, and hiring new personnel.

State Agency—The State of Wisconsin investigated the event on April 11, 2005 and determined that the licensee (1) failed to prepare a written directive prior to administering the Y-90, (2) failed to prevent usage of a dose that differed from the intended dosage by more than 20 percent, (3) failed to establish appropriate administrative procedures, (4) failed to ensure radiation safety activities were performed under approved procedures, and (5) failed to instruct individuals working under the supervision of an authorized user of the licensee's written directive procedures. A medical consultant contracted by the State of Wisconsin determined that no adverse medical effects occurred as a result of this medical event. As a result of the State's investigation, the licensee implemented the corrective actions detailed above. The State reviewed the licensee's corrective actions and found them adequate to prevent recurrence.

This event is closed for the purpose of this report.

AS 05–05 Therapeutic Medical Event at University of Utah in Salt Lake City, Utah

Criterion IV, ''For Medical Licensees,'' of Appendix A to this report states, in part, that a medical event that results in a dose that is (1) equal to or greater than 1 Gy (100 rads) to a major portion of the bone marrow, to the lens of the eye, or the gonads, or (2) equal to or greater than 10 Gy (1,000 rads) to any other organ; and represents a prescribed dose or dosage that is delivered to the wrong treatment site, will be considered for reporting as an AO.

Date and Place—August 4, 2005; University of Utah; Salt Lake City, Utah.

Nature and Probable Consequences—A patient received radiation therapy to the left bronchus using a high dose-rate (HDR) device. The HDR contained a 252 GBq (6.81 Ci) iridium-192 (Ir-192) source. The prescribed radiation therapy treatment plan called for three treatments to the left bronchus, each fraction to deliver a dose of 7 Gy (700 rads). The medical event, which occurred during the second treatment, was due to a 3-centimeter (cm) error in the source wire travel distance. The source wire distance was entered incorrectly by a medical physicist. As a result, a 3 cm length of the left bronchus received approximately 6.40 to 18.60 Gy (640 to 1,860 rads) at a 0.5 cm depth and 2.54 to 6.62 Gy (254 to 662 rads) at a 1 cm depth. A 3-cm region next to the intended treatment site received up to 6 Gy (600 rads) less than the prescribed dose. The licensee notified the patient and the patient's referring physician of the event. The patient received no adverse health effects from the medical event.

Cause(s)—This event was attributed to human error in that the treatment site was not verified.

Actions Taken to Prevent Recurrence

Licensee—The licensee implemented a new procedure adding a question to verify the treatment distances during HDR treatments.

State Agency—The State has reviewed and accepted the licensee's corrective actions. This event is closed for the purpose of this report.

AS 05–06 Dose to Fetus at Riverside Methodist Hospital in Columbus, Ohio

Criterion I.A.2, ''For All Licensees,'' of Appendix A to this report states, ''Any unintended radiation exposure to any minor (an individual less than 18 years of age) resulting in an annual total effective dose equivalent (TEDE) of 50 millisieverts (mSv) (5 rem) or more, or to an embryo/fetus resulting in a dose equivalent of 50 mSv (5 rem) or more,'' will be considered for reporting as an AO.

Date and Place—November 2 and November 16, 2004; Riverside Methodist Hospital; Columbus, Ohio.

Nature and Probable Consequences—On November 2, 2004, a patient was administered 7.59 MBq (0.205 mCi) of iodine-123 (I-123) as part of a diagnostic procedure for hyperthyroidism. On November 16, 2004, the patient returned for a therapeutic treatment and was administered 469.9 MBq (12.7 mCi) of iodine-131 (I-131) as treatment. Prior to this administration, the patient was counseled regarding pregnancy and acknowledged, in writing, that she was not and could not be pregnant at that time. A pregnancy test was not performed to confirm this declaration. Later, the patient saw her physician because of abdominal pain. A radiograph of the abdomen revealed the pregnancy. A prenatal specialist determined that the fetus was 17 weeks old at the time of the I-131 administration. The dose estimate for the fetus was 0.024 Gy (2.04 rads) to the whole body and 224 Gy (22,400 rads) to the fetal thyroid from both I-123 and I-131 administrations. The perinatal specialist performed a blood test on the fetus and confirmed that the fetus had hyperthyroidism. An ultrasound test on the fetus showed no abnormalities in fetal development. The perinatal specialist will perform treatments in-

utero to mitigate the effects of hyperthyroidism. The referring physician and patient were notified of the medical event.

Cause(s)—The cause of the event was human error. At the time of the administration, the patient was unaware of her pregnancy status and completed forms indicating that she was not pregnant.

Actions Taken to Prevent Recurrence

Licensee—The licensee has implemented a policy performing a serum pregnancy test and receiving the results within 80 hours of administration of therapeutic amounts of I-131. This test will be performed on all women 13 to 50 years of age, unless the women have been surgically sterilized.

State Agency—The Ohio Department of Health performed an on-site investigation on January 28, 2005 and determined that the licensee followed all required procedures. The State agency will conduct periodic inspections to ensure that the licensee's actions taken to prevent recurrence were implemented.

This event is closed for the purpose of this report.

Dated at Rockville, Maryland this 28th day of April, 2006.

For the Nuclear Regulatory Commission.

Annette L. Vietti-Cook,

Secretary of the Commission.

[FR Doc. E6-6746 Filed 5–3–06; 8:45 am]

BILLING CODE 7590–01–P

DEPARTMENT OF STATE

[Public Notice 5383]

Notice of Proposal To Extend the Memorandum of Understanding Between the Government of the United States of America and the Government of the Republic of Bolivia Concerning the Imposition of Import Restrictions on Archaeological Material From the Pre-Columbian Cultures and Certain Ethnological Material From the Colonial and Republican Periods of Bolivia

The Government of the Republic of Bolivia has informed the Government of the United States of its interest in an extension of the Memorandum of Understanding Between the Government of the United States of America and the Government of the Republic of Bolivia Concerning the Imposition of Import Restrictions on Archaeological Material from the Pre-Columbian Cultures and Certain Ethnological Material from the Colonial and Republican Periods of Bolivia, which entered into force on December 7, 2001.

Pursuant to the authority vested in the Assistant Secretary for Educational and Cultural Affairs, and pursuant to the requirement under 19 U.S.C. 2602(f)(1), an extension of this Memorandum of Understanding is hereby proposed.

Pursuant to 19 U.S.C. 2602(f)(2), the views and recommendations of the Cultural Property Advisory Committee regarding this proposal will be requested.

A copy of this Memorandum of Understanding, the designated list of restricted categories of material, and related information can be found at the following Web site: *http://exchanges.state.gov/culprop*.

Dated: April 21, 2006.

C. Miller Crouch,

Acting Assistant Secretary for Educational and Cultural Affairs, Department of State.

[FR Doc. E6–6773 Filed 5–3–06; 8:45 am]

BILLING CODE 4710–05–P

DEPARTMENT OF STATE

[Public Notice 5384]

Notice of Meeting of the Cultural Property Advisory Committee

There will be a meeting of the Cultural Property Advisory Committee on Thursday, June 8, 2006, from approximately 9 a.m. to 5 p.m., and on Friday, June 9, from approximately 9 a.m. to 2 p.m., at the Department of State, Annex 44, Room 840, 301 4th St., SW., Washington, DC. During its meeting the Committee will review a proposal to extend the Memorandum of Understanding Between the Government of the United States of America and the Government of the Republic of Bolivia Concerning the Imposition of Import Restrictions on Archaeological Material from the Pre-Columbian Cultures and Certain Ethnological Material from the Colonial and Republican Periods of Bolivia. The Government of the Republic of Bolivia has notified the Government of the United States of America of its interest in such an extension.

The Committee's responsibilities are carried out in accordance with provisions of the Convention on Cultural Property Implementation Act (19 U.S.C. 2601 *et seq.*). The text of the Act and subject Memorandum of Understanding, as well as related information may be found at *http://exchanges.state.gov/culprop*. Portions of the meeting on June 8 and 9 will be closed pursuant to 5 U.S.C. 552b(c)(9)(B) and 19 U.S.C. 2605(h). However, on June 8, the Committee will hold an open session from approximately 10 a.m. to 11:30 a.m., to receive oral public comment on the proposal to extend. Persons wishing to attend this open session should notify the Cultural Heritage Center of the Department of State at (202) 453–8800 by Thursday, June 1, 2006, 3 p.m. (EDT) to arrange for admission. Seating is limited.

Those who wish to make oral presentations at the public session should request to be scheduled and must submit a written text of the oral comments by May 24 to allow time for distribution to Committee members prior to the meeting. Oral comments will be limited to allow time for questions from members of the Committee and must specifically address the determinations under section 303(a)(1) of the Convention on Cultural Property Implementation Act, 19 U.S.C. 2602, pursuant to which the Committee must make findings. This citation for the determinations can be found at the Web site noted above.

The Committee also invites written comments and asks that they be submitted no later than May 24 to allow time for distribution to Committee members prior to the meeting. All written materials, including the written texts of oral statements, may be faxed to (202) 435–8803. If five pages or more, 20 duplicates of written materials must be sent by express mail to: Cultural Heritage Center, Department of State, Annex 44, 301 4th Street, SW., Washington, DC 20547; tel: (202) 453–8800.

Dated: April 21, 2006.

C. Miller Crouch,

Acting Assistant Secretary for Educational and Cultural Affairs, Department of State.

[FR Doc. E6–6756 Filed 5–3–06; 8:45 am]

BILLING CODE 4710–05–P

DEPARTMENT OF STATE

[Public Notice 5387]

Notice of Meeting United States International Telecommunication Advisory Committee

The Department of State announces a meeting of the ITAC. The purpose of the Committee is to advise the Department on matters related to telecommunication and information policy matters in preparation for international meetings pertaining to telecommunication and information issues.

The ITAC will meet to discuss the matters related to the meeting of the ITU Radiocommunication Sector's Special