ADVISORY COUNCIL ON RADIATION PROTECTION

Bureau of Radiation Control

Hilton Garden Inn Tampa Airport Westshore

Tampa, Florida

05/15/2018

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CERTIFIED TRANSCRIPT

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Hilton Garden Inn

Tampa Airport Westshore

Tampa, Florida

Tuesday, May 15, 2018

10 a.m. - 3:03 p.m

Reported by

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

ADVISORY COUNCIL MEMBERS PRESENT:

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

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

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

Christine Crane-Amores, RRA, RTCR

Rebecca McFadden, RT(R)

Brian Kent Birky, Ph.D.

William (Bill) W. Atherton, DC, DACBR, CCSP

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

Matthew Walser, PA-C, ATC

Nicholas Plaxton, M.D.

Adam Weaver, MS, CHP

Efstratios Lagoutaris, D.P.M.

FLORIDA DEPARTMENT OF HEALTH STAFF

Cynthia Becker, Bureau of Radiation Control

James Futch, Bureau of Radiation Control

Brenda Andrews, Bureau of Radiation Control

Douglass Cooke, Bureau of Radiation Control

Lynne Andresen, BAS, RT(R)(MR), Bureau of Radiation Control

Ginni Shaw, Bureau of Radiation Control

Clark Eldredge, Bureau of Radiation Control

Allen Moody, Bureau of Radiation Control

Gail Curry, Medical Quality Assurance

Anthony Spivey, D.B.A., Medical Quality Assurance

AGENDA

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MORNING SESSION

AFTERNOON SESSION

RANDY SCHENKMAN, CHAIRPERSON: Good morning, everybody.

COUNCIL MEMBERS: Good morning.

RANDY SCHENKMAN, CHAIRPERSON: Welcome. This looks like it's going to be a very interesting meeting. I'd like to start by everybody saying who they are. Let me start over here.

BRIAN BIRKY: Okay. I'm Brian Birky. I'm executive director of the Florida Industrial Phosphate Research Institute. We're part of Florida Polytechnic University and I'm here for environmental matters.

REBECCA McFADDEN: I'm Becky McFadden. I'm PACS administrator at Munroe Regional Medical Center in Ocala, Florida and I'm here as the certified radiologic technologist.

MATTHEW WALSER: Matt Walser. I work at the University of Florida in Gainesville. I'm the clinical coordinator of all the PAs and nurse practitioners in orthopedics for about 19 years.

NICHOLAS PLAXTON: I'm new to the council. Dr. Nicholas Plaxton. I work over, just on the other side of the bay at Bay Pines VA. I did my training up at Emory, my nuclear medicine residency, and then I did -- I also did time in the Air Force as a

flight doc. And I've been here about five years now as a physician here at Bay Pines.

CHANTEL CORBETT: Chantel Corbett. Certified nuclear medicine technologist at Fusion Physics, a medical physics consulting company.

CLARK ELDREDGE: Clark Eldredge, administrator for the radiation machine program, Bureau of Radiation Control.

LYNNE ANDRESEN: Lynne Andresen, enforcement coordinator for the radiologic technology section.

GINNI SHAW: Ginni Shaw, enforcement for the x-ray machine section handling medical events and violation corrections.

DOUGLASS COOKE: Douglass Cooke, business consultant, Burea of Radiation Control.

BRENDA ANDREWS: Brenda Andrews. I'm in the management and operations section of the Bureau. And I also work with James on the coordination of your council.

JAMES FUTCH: James Futch, health physicist administrator for technology standards and continuing education for the Bureau of Radiation Control.

RANDY SCHENKMAN, CHAIRPERSON: Randy Schenkman. I'm a retired radiologist. I worked at Baptist

Hospital in Miami and my specialty was women's imaging and breast imaging.

MARK SEDDON: Mark Seddon. I'm the chief physicist and radiation safety officer for the Florida Hospital system. Representing the Board certified medical physicists representing the MMPM.

CYNTHIA BECKER: Hi, I'm Cindy Becker with the Department of Health, Bureau of Radiation Control Bureau Chief.

GAIL CURRY: Hi, I'm Gail Curry, program operations administrator for the boards of chiropractic medicine, clinical laboratory personnel, nursing home administrators, optometry, EMT paramedic and last but not least, radiologic technologists.

(Laughter)

BRENDA ANDREWS: That's a mouthful.

ANTHONY SPIVEY: Good morning. I'm Dr. Anthony Spivey. I'm the board executive director for all of those boards she just mentioned. I'm also your new coordinator for MqA rad tech section and also former Air Force.

KATHY DROTAR: I'm Kathy Drotar. I'm the radiologic technologist therapy member. And I am the university department chair for radiologic

technology at Keiser University and vice-president of the Florida Society of Radiologic Technologists.

CHRISTEN CRANE-AMORES: Good morning. My name is Christen Crane-Amores. I'm the radiologist assistant for Radiology Associates of Tallahassee.

ADAM WEAVER: Adam Weaver. University of South Florida. I'm the radiation safety, laser safety officer there. And I'm the certified health physicist on the Board.

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

STRATIS LAGOUTARIS: Hi, I'm Stratis Lagoutaris. I'm a private practice and Navy reserve podiatrist. I live and work in Jacksonville, Florida.

RANDY SCHENKMAN, CHAIRPERSON: Well, welcome everybody, and our new people especially.

The next thing on the agenda is that we need to approve the minutes from the last meeting, which was 9-26-17. So do we have a motion to approve?

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

RANDY SCHENKMAN, CHAIRPERSON: Okay. All in favor, say yes.

COUNCIL MEMBERS: Yes.

RANDY SCHENKMAN, CHAIRPERSON: Anyone opposed?

(No response)

RANDY SCHENKMAN, CHAIRPERSON: Okay. So that passes unanimously.

And next, we have Cindy giving us the Bureau update.

CYNTHIA BECKER: Okay. Good morning, everybody.

COUNCIL MEMBERS: Good morning.

CYNTHIA BECKER: We all got soaked maybe last night, some of us did, but we're here today. It's not raining. All right. Good.

I think I say this every time we have a Bureau update, but we still have an interim division director, which with the level of the State, you know, we are a bureau and we're under the Division of Emergency Preparedness and Community Support and the interim director is Doug Woodliffe and he will be that way until the change of governor. So they want to keep everything like it is until that transition time. So that's who we are from there on down.

Our Bureau has quite a few vacancies. Really only five, I think, at the moment. We hate to see any. But our vacancies are being filled quickly

with Clark in the x-ray machine program, especially with the addition of Ginni. Yay. Glad to have her on board. He has one more vacancy to fill there. A consultant position. And we have a couple vacancies in Miami. Miami inspection vacancies. So if anybody knows anybody to send that way, that would be great.

We have some MQA changes, as they will discuss, I'm sure, later. Also have a very interesting talk presentation this afternoon with Allen Moody. He's our chemist administrator from our Orlando lab, environmental lab. I think you'll find that really interesting. We do have incidents, as you all know, and that one in particular he's going to talk about is extremely interesting.

I'm trying to get him or John to the Office of Agreement States/NRC meeting to also give that presentation.

And as we get more people on board with us and fill all the positions, I think you'll see we'll be working more towards developing and revising rules. Clark will talk about that later this afternoon. And trying to identify more ways that we can do internal quality assurance, standardization, look at trends and the new modalities that's out there. It

feels like, as you guys know in the field, it's always changing. Something is always new out there and we're just almost, like, hit in the face with it. You know, how do we handle this situation? How do we handle this new machine or this new radioactive material isotope? So it can be very challenging, but also very rewarding and interesting.

So I was thinking any other real changes we have in our Bureau. Not so much. I think you'll hear from a lot of our staff with our presentations and I think you'll find them quite interesting. And if you have any questions, we're always here. I think you know how to reach any of us at any time. And thank you for coming.

RANDY SCHENKMAN, CHAIRPERSON: All right. Okay.

JAMES FUTCH: So along the lines what Cindy was talking about, keeping up with new things, new technologies, new procedures, changes in the way old procedures are being used, we very much depend upon all of you to kind of be on the look out for that and if you see something that's coming down the pike or something that's beginning in your region of the state or your area of practice, please let us know.

Because it's probably going to eventually affect more than just your region of your state and your facility. And the guidance of the council is vital for the Bureau to adapt and change; create new regulations; amend old regulations when possible.

So I just wanted to mention that so you're always thinking that way in case you weren't already. But, well, thank you.

RANDY SCHENKMAN, CHAIRPERSON: Anybody else have any comments?

CLARK ELDREDGE: That theme is basically the talk, running through one of my presentations, the fact that a lot of the things I've got to talk about where technology or usage of new devices, current devices and new ways and new devices; that type of thing. So, yes, it is important and that's why I'm here with my talk is to get you all to give us guidance specifically on some of those types of things.

RANDY SCHENKMAN, CHAIRPERSON: Okay. Anybody else?

JAMES FUTCH: Speaking of new technology, the old technology in the middle of the room has just turned itself off. So while I'm doing this, back to you.

RANDY SCHENKMAN, CHAIRPERSON: So now we're going to go up -- we're going to do medical quality assurance and this is Dr. Anthony Spivey.

ANTHONY SPIVEY: Okay. Thank you.

Good morning again. I'm Anthony Spivey. I'm the new executive director for your group. We manage seven boards currently in addition to this one.

So what has occurred recently, this was under the Board of Pharmacy as an executive director, and I've been with the department about three years. And just to give you a little background on me before I get into the presentation on the changes.

I've prior Air Force. Spent 21 years in the Air Force. Retired as a financial manager. And coming out of the Air Force, I started working for the Department of Business and Professional Regulation as an executive director. First some other jobs and I was promoted to executive director, doing basically the same thing for the Department of Health managing the boards.

And so my background, I have a Bachelor's degree in management, a Master's in counseling and human resource development and my Doctorate is in business administration. So I've been with the

Department of Health about three years. And we've been working with our current boards to bring changes in the office.

We've got very good morale in the office right now. When I first started, it wasn't so good and the tide has changed. So I try to keep a pretty laid-back atmosphere in the office because people just don't work well under stress. And by doing that, we've got a lot of things accomplished. And so, my boss, Adrian, decided to move the area, the rad tech section over to our area because we were probably more able to give it a lot more attention. And I've been looking at some of your things in the background, just watching how procedures are being done and trying to get a full idea of what changes you may need and I'm not going to come in making any immediate changes.

What I wanted to do is just basically get ideas from the group, you know, as to what type of problems you're having, what you need done from the office as far as licensing, maybe consider, and look at different things we can help you do your jobs better.

For example, the -- when I left the deputy office yesterday, we were actually moving the staff,

current staff that's in your area for the rad tech section, over to our area. We're having cubicles built for the section and they were in the process of doing that when I walked out of the office yesterday. So they should hopefully be moved over by now when we get back in the morning.

We're also hiring a receptionist to handle the area. I'm trying get an individual that's in there that I can depend on that will be there every day. That will free up the processors from having to answer the phones so they can do more work and get the applications out a lot quicker. By doing that, that keeps them focused on what they're doing and having a dependable person in the office that can answer phones, that is stable and doesn't have a lot of issues to deal with on the outside. To come in, do the work and take care of the public when the calls come in regarding the application processes.

So we're going to be making some different -- additional changes in the office to allow for the staff to integrate into the staff that we have now. We've already, in fact, some of the staff that we have currently, they are actually augmenting some of the duties now for this profession to help the two individuals that are in there now. So one

individual is on medical leave, so I'm not sure when he will, when or if he will be coming back, so in the interim, what we'll probably do is end up hiring a temporary person to take, take some of the slack off the individuals to make sure the work is not too heavy on the people that's there now.

But as I said, what my -- my intention here today is just watch the meeting, see what goes on in this meeting and if you have any ideas or questions that you would like addressed regarding the application processes in the office. That's what I'm here for, because I'm not going to fix it alone. It's better to fix it with the help of you all because you all know what you need and the things that I can get done, we'll get done. If we can't get certain things done, then we'll tell you why. But that's -- if you have any questions of me, now is the time.

KATHY DROTAR: Actually, I do.

ANTHONY SPIVEY: Yes.

KATHY DROTAR: Congratulations on bringing Gail Curry back to us because --

(Applause)

KATHY DROTAR: Yes. Because since she's been gone and you, I'm sure, seen the problems that have

been there. But I'm telling you, Gail was coming, I was going to come in to inform the Board that -- or the council that it's actually, in the days when we used to do paper applications as a process for getting new grads their licenses and getting the permanent licenses in place took, was a shorter time frame than what we've been seeing with the online. And that it's not really terribly user friendly, the system --

ANTHONY SPIVEY: Right.

KATHY DROTAR: -- that's there and I just had a grad yesterday who got her ARRT information back and wasn't able to go in and upload what she needed to do, so she could transform the permanent one. I think part of it has been everything keeps changing. So every time you have a new group of students come in, which is about every four months for us, that it changes, and so, there's, you know, the consistency, it's improved somewhat, but it's still a little on the burdensome side --

ANTHONY SPIVEY: Right.

KATHY DROTAR: -- but we'll be very happy to work with you to help straighten anything out because we know because of that 1801 date that you can't always see what's on our side either, but

you're working on that. So thank you for being open to suggestions. We're look forward to working with you.

ANTHONY SPIVEY: And I'm also an advocate of technology because you can do it a lot faster on the computer and one of the things I mentioned in meetings at the department is, you know, I see commercial businesses that do things effortlessly because of technology and a lot of times, it's mainly because of the systems that we can afford to pay for. So, you know, I'm always pushing in the office to, you know, spend the money to get it right the first time instead of keep patching it continuously.

And also, speaking of Gail, Gail, you know, she's a program administrator, so she runs the entire area there. And also, we are hiring Friday, we have a new supervisor coming in to the area, Carla Rabey (ph). She will be actually the direct supervisor of this area. Until she gets up on board, you know, you can direct all your questions and inquiries to Gail. As soon as Carla gets into the position and is up to speed, then she'll be a point of contact. Like I said, we're getting the office up and running and my goal is to put it back

where it should be in a proper running place.

RANDY SCHENKMAN, CHAIRPERSON: Great. Anybody else have any comments, questions?

JAMES FUTCH: I just wanted to say to those of you that haven't seen the big picture, the group that Dr. Spivey and Gail are part of is not the group that was most recently handling the rad techs as Dr. Spivey said for the past what, three years, Gail, three years, something like that. And in the short time that they've been back to the new group, one of the things that I've seen is consistent supervision that's there all the time. That was, I think, one of the big contributing factors to when the front line staff were having issues, there were also some shortages in the front line staff in the new group, the supervision in between was not always able to be there and be consistent from day to day.

I think that what we've seen so far very much, I think that's one of the reasons that Dr. Spivey's bureau chief, Adrian Rogers, saw and decided to make the change. So that's very good.

And Kathy, how is -- and Becky, anybody else who's got students, how are we doing so far with the students? Is the school lists program letters being answered? Have you seen --

KATHY DROTAR: After I e-mailed Gail directly and said -- I e-mailed and said, you know, I have grads that have jobs and can't take the job because the license, temporary license hasn't been issued. And then Gail e-mailed back and those people got taken care of right away. But it's still a very slow process. But understanding that, you know, the personnel issues.

JAMES FUTCH: I kind of feel like we had some issues slip underground and then it's been kind of given to Dr. Spivey and Gail to resurrect and you've got some pieces. Go ahead.

GAIL CURRY: First of all, I'd like to say I'm glad that this group is back under me and Dr. Spivey, because we are very diligent about making sure that programs run the way they should. And I will let you know that right now, the process -- you have two processors that are working the whole State of Florida for EMTs, paramedics and rad techs. Two processors. Those two processors are also having to answer the phone. This was before we did some shifting. But the processors were also answering the phone a half a day.

When you're sitting on the phone, you can't get anything done. You can't get the processing of the

applications done because the phone rings constantly. Since we have taken over, the group that Dr. Spivey and I had originally, has stepped up. I have made phone arrangements where everybody goes down for an hour every day and does the phone. That relieves your two processors to process applications. That has alleviated some of the problems.

Right now, I'm working with James to get the process back in running order as far as the exam things because I don't really know what's going on. So James is guiding us through that, along with Lynne and Kelly Nesmith, who have been very beneficial to me. So I'd like to tell all of you thank you.

I can tell you that between Dr. Spivey and myself, we will get this program back where it needs to be. And I'd like to also reiterate what he said about letting us know what's going on on your side, because we don't know. We only see what we have in our office.

So give us a little time, but please stay in contact and let us know if there's something we can do better. If there's something that's just not how it should be. And then we can work on those issues.

And the last thing I want to say is that right now, I am very involved because I don't have a supervisor for your section yet, but once that supervisor comes on, like Dr. Spivey said, that person will be your initial contact person because I have all those other boards I have to take care of. So change is coming and it's going to be, it's going to be good. Thank you.

JAMES FUTCH: Along the lines -- Carla, I met Carla. She seems like an excellent candidate, excellent supervisor. She had -- the thing I liked, she has experience in, already in the lovely computer system that we all deal with inside the department; the online system that you deal with from the applicant's perspective and she's -- and she has many different groups she's worked for inside of MqA. She seems like a really competent supervisor for the staff. Now you just have to have, put more staff to supervise. We'll get that going.

That's it for me. I'm just standing up here waiting to turn the lights off.

RANDY SCHENKMAN, CHAIRPERSON: Okay. Anyone else have anything to say?

Okay. So now we're going to go on to Lynne.

JAMES FUTCH: I'll make this so you can actually see the screen. See if the buttons do the same thing it did last time. There you go. Nice and cozy.

LYNNE ANDRESEN: Good morning, everyone. I'm Lynne Andresen.

COUNCIL MEMBERS: Good morning.

LYNNE ANDRESEN: I work for James in the radiologic technology section. I'm the enforcement coordinator. And I thank you all for coming today, for your time, your expertise, your contributions to the council and to our profession.

I handle a lot of things for James besides just enforcement. You know, anything with MQA as far as applications; renewals. I interface or work with the Bureau of Enforcement, with CSU, ISU, PSU, with ARRT.

I'm going to talk a little bit about the profession, application requirements, discipline, medical events. I'm going to hand it over to Ginni Shaw, my enforcement counterpart with the radiation machine program, and then pick it back up and offer you some case examples and let you kind of know where we are with case load, as far as in PSU and resolutions and cases.

So the licensure statute is Part IV, 468, and it was actually created in 1974, and it's the reason the council exists. And you can read a little bit here about what that statute says.

And basically, it is the purpose to establish standards of education, training and experience and to require the examination and certification of users of radiation and radiation-emitting equipment.

Here's some approximate numbers for the different licensure. You guys can read that. And some of you guys actually hold licensure. I know I do myself; Ginni does. And then some of you actually represent some of these areas.

And you can see there's a difference in the total number of licenses and total technologists and that's because some technologists actually hold more than one license.

There are two pathways for licensure: Examination and endorsement. So the applicants that come in through examination, they are required to complete an application, along with a fee. And this can be in paper form or an online format. And this will go through Miss Gail and Dr. Spivey's area. They have to be at least 18 years of age at the time of the application and very importantly, be of good

moral character. Not have committed any offenses that would be grounds for discipline under our discipline standards. And they have to have successfully completed a two-year accredited radiologic technology program.

You guys remember back last September when we had the hurricane and that adversely affected Puerto Rico. And we had an influx of people coming into Florida and so that created a lot of extra review on the part of MQA for educational backgrounds to be essentially equivalent. And then with our team as well, Kelly and myself. We actually manually reviewed, reviewed all those applications that came in from Puerto Rico. And we're still reviewing to this day.

All right. There are two background questions on the application, which you can read, basically, and it's a yes-or-no answer. There's no maybes. There's no not answering the question. So once they answer yes, then it goes through a process of them completing a background history form and submitting the required information, as you can see, anything that would correspond to their offense.

Disciplinary guidelines under Rule 64E-3.011. So any time an applicant, employer, certificate

holder or other person has committed any of the acts set forth in that statute, the department can impose penalties as recommended in these guidelines.

Up on our website, under the Florida Department of Health, you can access the statutes and review them that correspond with our profession. The rule, the administrative code, and also, the disciplinary guidelines. So those are available to the public. Anyone can look at them at any time. And all violations are sufficient for refusal to certify an applicant.

If I'm going too fast, you guys let me know.

Many factors are considered when determining discipline and this reviews some of them. Danger to the public. The number of offenses this person's committed. The length of time since the date of the violation. The length of time that they have practiced. The actual damage caused by the violation. Previous disciplinary action by the department, by a national organization or registry, which would mean if they've been sanctioned by ARRT. And also, prior rehabilitation efforts. So maybe if they have gone under some sort of rehab or PRN before in the past.

We go back to disciplinary grounds and actions.

So the department may make or require any investigations, inspections, evaluations, tests. We can require submission of any documents, statements that we feel are necessary to make a determination whether a violation has been made.

That -- and a lot of times, you know, that could be maybe we require some sort of medical examination, additional drug screening, PRN evaluation, additional inspections, maybe through the Bureau, for an inspector to go back out, or investigations through the Bureau of Enforcement with MqA.

All right. These are some of the examples for grounds of discipline: Obtaining or renewing a certificate through fraud. That could be at our level, the State level, or at the national level, through ARRT. A certificate that has been revoked, suspended or acted on by a specialty board or certification authority of another state. That would be like maybe their license had been acted on from another state.

Being convicted or found guilty of a crime that directly relates to the practice of radiologic technology or their ability to practice.

Being convicted or found guilty of a crime

against a person. Making or filing a false report or record that the certificate holder knows to be false. And the, seems to be the catch-all, engaging in unprofessional conduct.

And being unable to practice radiologic technology with reasonable skill and safety to patients, by reason of illness, or use of alcohol, drugs, narcotics, chemicals or other materials. Basically, impairment.

Failing to report to the department any person that the certificate holder knows is in violation of any rules of the department.

And this seems to be another widely used one: Violating any provision of this part or any rule of the department.

Employing any individual who is not certified to practice radiologic technology could be an unlicensed activity.

Testing positive for any drug or -- on any confirmed pre-employment or employer-required drug screening.

Failing to report to the department within 30 days if they've had anything -- any action against their certificate or otherwise acted against by a national organization such as ARRT.

Having been found guilty of any offense under 435.04 or a similar statute. And failing to comply with recommendations of the department's impaired practitioner program, which would be PRN.

At this time, I am going to transition over to Miss Ginni Shaw with the radiation machine section. She's going to go over a few things for you guys. Regulatory authority, medical event reporting, medical event investigations and medical event enforcement and administrative fines as they relate to that section or the facility side of things.

Ginni?

GINNI SHAW: Thank you. All right. Medical events. Each state is independently responsible for regulating radiation equipment. The State of Florida Bureau of Radiation Control is responsible for that in Florida. This is authorized under Chapter 44 in the Florida Statutes and Chapter 64E in the Florida Administrative Code.

As one of the responsibilities of this, the Bureau also receives and evaluates reports of medical events.

Approximately 50 percent of states have regulations with mandatory reporting requirements of medical events and Florida is one of those.

Here are a couple of voluntary reporting programs. So you have Radiology Oncology Incident Learning System or ROILS. That's going to be for the facilities to report and the Conference of Radiation Control Program Directors, CRCPD, that's going to be more for the state and local agencies to report.

ROILS is sponsored by AAPM and ASTRO for accredited facilities. Their mission is to provide shared learning and prevent errors, that sort of thing, in a secure, non-punitive environment. They also receive tips and tools. They have webinars available for the facilities. You can track your internal incidents and near misses; those types of things. And so receives tips and tools, best practices and general patient safety initiatives for them.

And here are their requirements or what kind of constitutes an event or condition for them. So omitted procedure, wrong site, wrong patient, wrong procedure, wrong modality and/or laterality. I can't say that word. Total or partial geometric miss. Wrong dose to all or part of tumor or normal tissue and mechanical failure.

So CRCPD is going to be for, like I said, the

states and local agencies with reporting requirements in place. They do have a committee on radiation medical events, the Healing Arts Council H-38. Same sort of goals, shared lessons learned, prevent errors, look for trends, improve patient care and safety; that sort of thing.

These are what constitute a medical event for CRCPD. And this is kind of going to look a lot -- very similar to what ours is in Florida Administrative Codes. So wrong patient, treatment modality or treatment site. Weekly dose differs by greater than 30 percent from the prescribed dose. Total administered dose differs by greater than 20 percent from total prescribed dose. Fraction dose differs by greater than 50 percent for any single fraction of a multi-fraction treatment.

Equipment failure, personal error, accident, mishap or other unusual occurrence that causes significant physical harm to a patient.

So then we'll go to medical events in Florida Administrative Code. I'm going to go over these three here because that's what we handle in our section: The therapeutic x-ray machine, particle accelerator and electronic brachytherapy.

So definitions for therapeutic x-ray machine

and particle accelerator you're going to find in 64E-5.101(85) and then the definition for electronic brachytherapy is going to be 64E-5.1601(8).

So radiation from a therapeutic x-ray machine or particle accelerator that results in any of the following is what's going to constitute a medical event: Unintended permanent functional damage to an individual's organs or a physiological system as determined by a physician. Wrong individual, which happens, surprisingly. Mode of treatment. Wrong treatment or wrong treatment site. Fractionated treatment of fewer than three fractions where the total administered dose differs greater than 10 percent of the total prescribed dose. Weekly administered dose is greater than 30 percent of weekly prescribed dose and total administered dose differs by greater than 20 percent of total prescribed dose.

This is for electronic brachytherapy. Except for one called by patient intervention. So anything that the case -- the patient kind of does to mess up their, their treatment wouldn't, wouldn't count for this.

Total dose delivered differs by greater than 20 percent of total prescribed dose. Single fraction

of a fractionated dose off by 50 percent or more. Of course, wrong individual and wrong treatment site.

So we had five medical events reported to the Bureau in 2017. There were three wrong sites, one wrong patient and one wrong dose.

We do have reporting requirements, like I said before. So this is going to be found in 64E-5.345, reports of medical events.

So the notification requirements. They have to call the Department by telephone no later than the next business day. They have to notify the individual or the responsible relative or guardian of the individual within 24 hours. That is unless the referring physician has already done so or the referring physician believes informing the patient would be harmful. In this case, they would have to give us medical justification as to why they didn't tell the patient.

They also have to report -- give us a written report within 15 days. So that report is going to include the referring physician's name, the prescribing physician's name, a brief description of the event, why the event occurred, their corrective actions, what they have done to prevent reoccurrence

and whether or not they have told the patient or not. And if not, like I said, give us a medical justification.

It shouldn't include any information that's going to identify the patient. So no names, no date of birth, nothing at all that can show us, you know, lead to us knowing any information about the individual, themselves.

So after the report, what comes next? So after they submit that report to us, we set up a site visit by the state investigators. And there's also a possible notice of violation, possible fine for the facility and possible fines to the individual.

The site visit. So it's state investigators. It says two to four. There's going to be, in our case it will be me and Miss Lindsey. You have someone from enforcement from the x-ray machines. You have someone in enforcement from technology and then you could also have someone training or you could have, like, an inspector come with you. Someone like that. So typically two, but it can be up to four.

There's going to be an entrance interview and overview of investigation process. This is typically going to be with management. We'll go

over the results of the facility's investigation, their internal investigation and corrective actions that they've taken.

We will do interviews with physicists, chief therapists and dosimetrists or therapists involved. And these are just individual interviews. We can do interview with an oncologist. If it's necessary, we can do an interview with the oncologist. They will show us documentation of existing or recommended procedures and training. Sometimes they will change their policies and procedures, so they will show us all those records. There will be an exit interview with management and then an overview of the administrative fine process.

Decision making. So after the site visit, we'll come back to Tallahassee and we kind of put a report together. We kind of try this 15-day thing. We try to do it -- we're going to try anyways. So they have to let us know within 15 days. We're going to try to have a site visit within 15 days and then we're going to try to have the draft report completely done within 15 days. So that's our goal for sure.

The report includes a synopsis of the event, the individual interview statements from the

therapists; the facility's corrective actions. And then it's going to include their written report and then any records obtained during the investigations we'll include as exhibits. Any of the medical records, which are, of course, redacted and the treatment plans and the prescription and all of that stuff will be included as well. And then the report will be used by the agency to identify violations and their severity.

Authorization for enforcement. This will be in Florida Statute Section 404.162. We can modify, deny, suspend or revoke a license or registration. Administrative fines are not to exceed $1000 per violation per day.

And, of course, we consider a lot of factors. So the severity of the violation, the actions taken to correct the violation, any previous violations. Just the fact that they reported, we take that into consideration as well as many other things.

So you'll find in the general statement of policy and procedure for radiation machine enforcement actions. It's kind of -- that document has violations for all types of things. So even just the machine violations that we find when we go out and do inspections; that sort of thing, but

there are some medical event violations up in the higher severity levels.

Primarily, it's just going to be administrative fines, but they do have potential for criminal penalties just based on the severity of the violation. There's severity Levels I through V. I being the worst.

So fines are generally imposed for initial Severity Levels I and II violations. Fines for Severity III through V are unlikely, but they are possible for repeat offenders. If we have someone making the same violation over and over, having the same reason for a medical event happening and they're obviously not taking corrective action, then we would, even if it's a III through V, then fines are possible.

Individual penalties. So the Bureau can also impose discipline against individuals and that's where Miss Lynne comes back in and sort of talks about the enforcement on the radiologic technology side of things. Thank you.

LYNNE ANDRESEN: Okay. So once the radiation machine section, they've completed their side of the report, then the -- actually, the report is forwarded and the information to our section, the

radiologic technology section to review. Basically, James and myself. And if the event involves any potential infractions of any health care practitioner, not just radiologic technologists, then a complaint will be submitted to the Division of Medical Quality Assurance or MQA and we'll include all the relevant information that we have.

Once it's received in MQA, it will be actually forwarded to the Consumer Services Unit or CSU and a case number will be assigned. That information will then be put into LEADS. That's their online database. It may be forwarded to ISU, the Investigative Services Unit, but it will, ultimately, the case will end up in the PSU or Prosecution Services Unit of the Division of MQA.

I want to tell you a little bit about the differences between CSU, ISU and PSU.

So CSU, that's where the case will start out. It's responsible for the initial intake of the complaint or any complaints, actually. And they will actually conduct an analysis and determine if the complaint is legally sufficient.

At that point, the complaint would then go to ISU, more than likely, and they are responsible for the actual investigation process. They'll conduct

interviews, they will collect documents and evidence, they will prepare reports; serve subpoenas and any official orders for the department. And then at some point, they will transition the complaint to PSU.

The PSU are the attorneys and they are responsible for the legal aspects of the complaint and they also regulate all the health care boards and councils.

Once the PSU attorneys review the complaint information, they will recommend a course of action based on probable cause, and these actions can include an emergency order, expert review, a closing order, or an administrative complaint.

Sometimes when they receive these cases, since this is not their area of expertise, they will request an expert review. And I would just like to share that we've got Kathy Drotar participates with this process and does offer expert review from time to time with PSU and we appreciate her service.

This timeframe is very individualized and can be very lengthy. And that the timeframe includes from the submission of the complaint to PSU, to the end or the closing or final order.

If the technologist involved with the complaint

is registered on a national level with ARRT, ARRT is notified. They do have their own ethic guidelines and procedures and they will process any investigation independently from ours.

And then unless an emergency order has been issued, the technologist may continue to work in their field. I don't know if any of you use the online look up for a technologist, but when you go to look up to see if they are expired or active, there's also another tab for any disciplinary action. And the technologist may be under investigation or they may have an active complaint, but like I said, unless there has been an emergency order issued, they can still work.

All right. So we have some cases pending with MQA that I track on a routine basis. They are in the LEADS database. And right now, there are approximately 91 open cases with MQA. There are about 10 percent in the consumer services unit, which are basically the ground level of the complaint process; about 30 percent with ISU that are being investigated, and the majority of them are actually with the attorneys in PSU.

Now, this caseload includes radiologic technologists, unlicensed individuals and

facilities. A lot of times, our inspectors with BRC, when they go out to conduct their inspection of a facility, they may run across individuals who are actually out there taking x-rays and are unlicensed. So a complaint will be initiated and sent to MQA and they will investigate the individuals and a lot of times, of course, they would be fined and additional action will be taken.

These are some examples of cases that we have open with MQA. There can be medical events. Unprofessional conduct. Unlicensed activity. Those with a history of current or previous ARRT sanction. And here's a new one, default on student loans. So they are taking that seriously. Probably, I would say there are probably 15 or 18 cases in that total caseload that are technologists that have been deficient on their student loans.

Impairment, including history or current use of drugs, DUI, positive drug screen, et cetera. Sexual misconduct and fraud.

Okay. So these are the cases in terms of the fiscal year. So as -- I think you remember me saying that these cases can be rather lengthy. The process. So we have 3 percent of that total number are going back from fiscal year 2014-15; 7 percent

back from fiscal year 2015-16; 30 percent from 2016-17 and 60 percent are within our current fiscal year.

So I'd like to give you a couple case examples of some of the cases that we're currently tracking and that are open with MQA.

This one is an example of engaging in unprofessional conduct. And this was a medical event. So we received the complaint and this was -- this dates back to 2013, where a 59-year-old patient received one fraction of radiation treatment delivered to the wrong site. And this medical event was actually not reported for more than four months. And this is still an open case back from 2013.

Here's another -- this is an example of the statute loan case. And it -- the complaint actually comes from the Florida Department of Education. And it's my understanding that the individual is sent correspondence and they are actually able to mediate and come up with a payment plan with the Department of Education. So as long as they comply with that, then they take them off, you know, the case list.

Okay. So this is a violation -- an impairment violation. And this is a true story. So we received the complaint and the subject provided

response on the website, when trying to renew his license, making harassing statements and wild accusations, including that the Department wanted him to die. A preliminary inquiry was made to determine the subject's welfare. Subject stated to the sheriff's deputies that he takes medication for depression and that he wanted to blow his head off with a gun. The subject was taken into custody under the Baker Act and transported to the local medical center.

I believe his license is expired. I think so. But we do receive some, some that are a little out there like that.

And then this is an example of an individual whose ARRT license was received -- a sanction, a suspension. So we actually received information from ARRT that they suspended this individual's license due to criminal charges in another state relating to sexual misconduct. And I don't know if you guys remember, we had a reporting requirement that if they do have history of sanction with ARRT, that they are to report that within 30 days. Because even if they don't, ARRT will report it to us. So it's best be honest, basically.

All right. Do you guys have any questions for

either Ginni or myself? Facility related, technology related?

REBECCA McFADDEN: I have a question.

LYNNE ANDRESEN: Sure.

REBECCA McFADDEN: The facilities -- obviously, we -- if the employee doesn't pass their drug test or drug screenings, you know, we, obviously, will terminate them if they don't declare it prior to and go through some rehabilitation.

What is the requirement of that facility and how do they go about reporting that to the Department of Health? Because, obviously, it's the individual's responsibility to report. But what is it -- what is the facility's responsibility as far as being, you know, a clinical facility and, and employing someone who doesn't pass that?

LYNNE ANDRESEN: James, would you like to add anything to that? She's asking about the facility's side versus the technology side.

REBECCA McFADDEN: Requirements. Individual.

JAMES FUTCH: For --

REBECCA McFADDEN: For drug screening. Like --

LYNNE ANDRESEN: Like impairment.

REBECCA McFADDEN: -- for impairment, yes.

JAMES FUTCH: There is a requirement for when

you take action against somebody. You guys -- what usually comes to us on the impairment stuff, it seems someone, a person is self-reporting. The fact the person self-reports, they self-report to the impaired practitioner provider, PRN, and under law, they don't tell us about anything. They try and help the person with the impairment and they won't report them to us until the person stops complying with the requirements of the program for drug testing, all the rest of it.

But when you guys take action against someone, it's often their -- you see some sort of probable cause to test them at work. You go through the process of testing and then it's your department that does this.

REBECCA McFADDEN: HR.

JAMES FUTCH: Human resources. Your group reports it to us just like they do Code 15 reports and some other sort of things that happened to a patient. So that's how it comes to us. And we very much appreciate that. That happens.

And in terms of you all's liability, if you don't, I'm not the lawyer, but I think if you're not going to take --

REBECCA McFADDEN: Well, a situation had come

up and this was the reason that we had a staff that we had someone who we did have to let go for that reason. And it wasn't -- and within weeks, that they started employment at another facility locally. So when that happened, you know, I, you know, it kind of troubled me, so obviously, I reached out to that management.

But I just, you know, I just wondered what, you know, how that could happen. I mean, obviously, she had gone through the, you know, the protection PRC course.

JAMES FUTCH: PRN.

REBECCA McFADDEN: PRN.

JAMES FUTCH: But you know, you saw the timeline on these cases. We took a big picture approach to this whole subject. We wanted to give you -- we talked so much in the past about medical events. We kind of focused in on that. We wanted you to step back and kind of have a big picture for how all of this ties together.

So Lynne started off in the beginning talking about people coming into the profession. Because one part of coming into the profession you saw is good moral character. Well, Randy leaned over and said, how do you tell somebody is good moral

character? You just ask them, of course. Everyone is honest.

REBECCA McFADDEN: Facebook page. What do you mean?

JAMES FUTCH: Being of good moral character concept is something from the 1950s. It's quaint, it's nice, but case law has pretty much rendered it almost moot.

So the other part of the incoming statute which also ties into discipline is, we have a statute that says we may not serve on somebody who's committed an act that would have been a disciplinary violation, if it had been committed when they were certified by us. Of course, they're not certified with us yet. So that's why it ties into all the rest of these discipline statutes. On the front end, a lot of times, occasionally we have someone who does that.

But the big picture on all this is there's lot of different ways for complaints to come to the department. Some through our inspectors, some through medical events, some through lots of other mechanisms by which you decide you report. They had to fire somebody; take some sort of action against them.

The 60 percent -- was it 60 percent -- over the

past fiscal year, currently 91, and there's a couple that are two or three or four years old. That's sad. But that's actually quite good if you look at some of the other professions. There are 30,000 technologists and there's only 90 cases, of which a fair percentage them are student loan that come to us in this process.

But the point I was trying to make was, you report someone. It could be literally years before we're able to take any action against them. Which is why we appreciate when the national registries, ARRT or NMTCB reports folks to us. There's a national practitioner databank that states report to. But given our own experiences, it could literally be several years before we're able to actually take an action against someone. And if it's impairment related, then you have the whole PRN kind of sideways requirements. Hands are tied while the person tries to get their act together with PRN's help, and that works out sometimes.

But that time frame also can add to the delay. So you may take an action against them, and we're going to get involved. At the point where they go to PRN, we're going to stop because we have to. It's a requirement. And then they're going to do

PRN possibly a couple years and then come back to us. If they stop complying, unfortunately, it's got to go back through the process. It could be a really long time. So the answer to your question --

REBECCA McFADDEN: They can technically just keep their license.

JAMES FUTCH: Nobody else is going to know except for you.

REBECCA McFADDEN: Right. Not just in this situation, but even if they have committed a crime, it's the same situation where we can have people out there licensed and --

JAMES FUTCH: Yeah. You saw one example that said, ARRT that reported someone who had allegations of criminal activity.

So what happens on the crime side is, typically, 95 percent of the time, we wait. And they open the case. They have all the information, make some preliminary inquiries and they put it on hold and wait for the legal system to do its thing and wait for if the person is found not guilty and/or they're going to drop the charges. An awful lot of time, it's something involving a crime with drugs, and the rest of it, especially if it's the first offense, they're going to do a diversionary

process and they will exit the legal system after a year of complying with whatever the terms of that were, you know, monitoring and community service and the rest of it. And that will end up in charges being nol-prossed and not prosecuted.

So the criminal side of it, factor another year or two possibly, until something actually happens and you've got some judgment that says, yes, you are --

REBECCA McFADDEN: Wow.

JAMES FUTCH: -- either found guilty or the statute doesn't care. You can be adjudication of guilt withheld.

REBECCA McFADDEN: But not reporting that adjudication withheld or not reporting that you are under possible crime, when you go to renew --

JAMES FUTCH: We ask them in the renewals.

REBECCA McFADDEN: Right. So how does that actually -- what if they didn't put it in there? I mean, does the State have access to that in their databases that this person has been charged but not held --

JAMES FUTCH: I guess technically, we do. We're not looking for that.

REBECCA McFADDEN: I'm just wondering about the

renewal process and, you know, how -- if you're answering the questions, if someone doesn't answer them truthfully.

JAMES FUTCH: Sometimes -- we had a gentleman once who, this was up in Jacksonville -- and some of these things are such a severe nature, directly can affect the patients. There's so much evidence.

What happened, so we had a gentleman in Jacksonville who was an interventional tech. And this one came to us by the newspaper. He was switching out morphine for saline. Putting saline and stealing the morphine from the auto injectors. He would go in and set the room up and he would just swap out the doses. So he was taking the morphine for himself. And I think he was selling it, too, maybe. And can you imagine how much fun that procedure was and that surgery with saline instead of morphine?

So he was -- that was a big splash across the news. That one we had -- the department has the ability to do an emergency suspension. You heard Lynne talk about that. And that's basically -- this is my two, this is my two cents, not a lawyer way of explaining this -- but this has such high visibility and there's such direct access to patients to affect

lots of peoples' immediate health care outcomes. And there's so much evidence we saw on the video, in the room, doing it. He admitted to it. There's not going to be a question. Even if somehow he manages not to be convicted, we're still going to order a suspension order. Those are really hard to do. It's really hard to get all the attorneys to actually -- I shouldn't say that. The attorneys often want to, but to make it through the, all the hoops they have to jump through, that is a high bar for folks to, to leap through. So --

REBECCA McFADDEN: Well, thank you. I mean, it's surprising to me that it is that difficult, you know, when people are out there committing crimes, licensed professionals, you could potentially put a patient in harm. So that's just my personal opinion, I guess, with it.

JAMES FUTCH: So, I'm sorry, your talk -- any questions?

LYNNE ANDRESEN: I had something I wanted to say. Somebody has a question?

I just want to say we work very hard to create a positive pro-active relationship with MQA. You know, the licensure renewal area, and we look forward to working with you guys. And we work very

hard to create a really good relationship with the Bureau of Enforcement, especially the PSU attorneys so that we can work through some of these cases. And we met with them last week and reviewed, what was it about, maybe 17, 18 cases.

JAMES FUTCH: In total 18. They added a few of them.

LYNNE ANDRESEN: And so that -- I mean, you look at the total number of about 91 and 18, that's, you know, a significant number. And so they are working -- I mean, some of them are going to be actually dismissed. Some of them are administrative complaints. So they are working, you know, I think at this point in time, hard to try to work through them, that total number. Don't you agree, Jim?

REBECCA McFADDEN: I think the total number is very low, to be honest. I mean, I feel like there are a lot of things out there that haven't been reported, I guess is where I'm going to -- or that we don't know about yet.

(Mobile phone rings)

REBECCA McFADDEN: Whoo, that's --

(Laughter)

JAMES FUTCH: By way of introduction, this is Allen Moody. Everybody is reaching for their cell

phones now.

So there were two more points. One of which is, I apologize for the AC unit to be on that side of the room because it's really kind of hard to hear back there. It's really quiet over here. You can hear everything, but over there it's a little harder, so we'll try and speak up. Me especially, a little bit more.

I wanted to ask -- a couple things. This is such a highly technically inclined profession, professions. We have the nuclear medicine side; radiation therapy side. There's 2,000 nuclear med techs and roughly 2,000 radiation therapy techs and some odd whatever number you said, 19,000, 20,000 radiographers. And then you get down into the interventional ones and all the rest of it.

We really could use more experts willing to help either the Bureau of Radiation Control on its own side dealing with machines and dealing with rad materials licenses, helping with the -- persons that want to sit on the council, but also on the disciplinary side and on the side, for the technologists, but also on the side dealing with, deciding to take action against a facility.

We're always looking for some more folks who

are willing to be expert witnesses. There's actually a committee for -- maybe Kathy can tell us about it.

KATHY DROTAR: Abbason.

JAMES FUTCH: Abbason. So there's a company out there that is contracted to the State of Florida Department of Health to supply expert witnesses. So there's this extra little bit of, I don't know what you call it. Protection, because it's a company and you're working for the company. So something about your liability is different. So that makes everybody feel better.

Especially if you have any colleagues, yourselves, other folks, retired technologists, in whatever particular field you're in. It's hard to get the cases prosecuted. The lawyers are great people. We're often a training ground for folks fresh out of law school that go to work either at the State Attorney's Office, they go to work for the Department of Health. It depends on if you want to do criminal law later on, if you want to do some kind of administrative law later on. But they really don't have a lot of direct experience. Some of the senior people have been there for a while do.

So it helps to have people who are willing to

be experts in the State of Florida. I'll give you an example. I actually testified in a federal, a federal court several years ago. They wanted -- they had a facility owner, materials licensee, also a radiologist, I think staff who was accusing him of doing things in some improper way.

And somehow I gotten snared in this because, you know, my name is on the website some place. And I had to actually go -- they subpoenaed me and also some of our inspectors. I think Neil got, one of the other guys got pulled into this. And had to go to Ocala; had to testify. And the only thing they wanted to know was whether PET/CT was nuclear medicine. That was it. That was the whole thing.

You go through all of that, you know, here's the folks on this side, the folks on that side, and they were, like, arguing over points of this, that and the other thing. We're admitting this, no, Your Honor, we can't admit that. And finally, the judge just had kind of enough of it and he just leaned over to me and said, Mr. Futch, if you can just tell me this. Is this PET, is this, is this nuclear medicine? And I'm like, yeah. There's like 6,000 places that you could have, you know, figured this out.

But the expert review stuff, it seems like that we could really use some help and assistance in those areas. You do have to be willing to go and testify and back it up, whatever you say in writing, if somebody wants to take it to a hearing. Which is, you know, the same thing you said to begin with. Okay. Is that it?

LYNNE ANDRESEN: Mm-hmm.

JAMES FUTCH: Who's next?

MARK SEDDON: I have a question, actually. Did we ever have an update on the wrong site medical event definition? I know the last time you presented some options.

JAMES FUTCH: I think --

CLARK ELDREDGE: Actually, I realized a few minutes ago I forgot to include that in my presentation.

MARK SEDDON: Okay.

CLARK ELDREDGE: Yeah, because we were actually, I had something written out about a month ago and when I put -- I left it out. I was going, why did I do that?

KATHY DROTAR: Quick question. Any possibility that we might have a mechanism for pre-approval for first-time applicants or, like, new students that

are coming in to the programs that might be able to, if they've got something, like a DUI or something, that they would be -- because ARRT, as you know, has the pre-application process. But even when they go through that ethics review, if they are approved, then the State also does a review once they apply for the license. But they won't know until, like, before, until, like, they're ready to graduate from their program. And sometimes there are -- they go through, what is it, the PRN program and then they have requirements or maybe not granted a license.

CHANTEL CORBETT: This is a silly question, but why would they not know that they have those issues?

KATHY DROTAR: No, that they know they have issues, but are they going to be able to be granted a license.

REBECCA McFADDEN: We had a situation where we had an applicant for the program --

JAMES FUTCH: Before they spend two years.

CLARK ELDREDGE: Before they spend the money and the effort.

RANDY SCHENKMAN, CHAIRPERSON: And the time.

KATHY DROTAR: To advise students better on whether it's --

CHANTEL CORBETT: I would think if you have a violation that potentially is going to prevent you from licensure, I would think that you would take the initiative to check on that.

KATHY DROTAR: But you don't know and there's no way you know until you make the application. You can't make the application until three months prior to graduation from the program.

JAMES FUTCH: Yeah. This has come up before, so I understand what you're asking. And the short answer is, nothing has changed with regard to our statutory authority. The best advice that I've been able to give in that regard is to have them apply for the basic operator. Because the basic operator can be granted without the two-year program. They self-attest to review the study guide, which is actually, we're going to talk about a little later, sitting over there on my desk, on my chair.

So the good thing is, whichever one of the different kinds of licensure you're applying for, all of the stuff that you're talking about is done for all of the different licenses. So if someone wants to go into the radiography program at Keiser or the nuclear medicine program at, what is the name of it? St. Andrew -- they can apply for the basic

machine operator. You have to be 18. You self-attest to having reviewed the study guide. And the rest of the legal stuff, all that will work our way through. It will take a little while to put all the paperwork together.

If we grant that, we're not going to change our minds two years later when they graduate as a radiographer, the rest of the program. That's the closest that we can come up with that I know of right now.

KATHY DROTAR: Thank you. Yeah, because if there is an issue, it could take four months for the license to be, to be issued because of that review process. Thank you.

MARK SEDDON: I have a couple questions. Going back to your presentation.

So the discipline that we're talking about here, the medical events is machine-based only. Materials, it would be not Ginni, but somebody else coming from Tallahassee? If there was a materials medical event?

GINNI SHAW: For materials?

LYNNE ANDRESEN: Yeah.

JAMES FUTCH: So Lynne would end up being involved, but Clark and Ginni are on the actual

machine side.

MARK SEDDON: Right. But the process is still the same. It's just different individuals.

JAMES FUTCH: Mm-hmm. Do you want to add anything?

CYNTHIA BECKER: We have very few issues on the materials side. It would be somebody from the materials program, like Ginni from the x-ray program, but it would still be Lynne, possibly, if it was a technology.

MARK SEDDON: Right. It's still the same for -- the process is still the same.

CYNTHIA BECKER: Right. Of course, the inspector.

REBECCA McFADDEN: I'm sorry to interrupt you, Mark. To get in touch with that person, how would we --

CYNTHIA BECKER: On the materials side?

REBECCA McFADDEN: Is it on the website?

CYNTHIA BECKER: On the website, yes. It's the radioactive materials section and there's, Charlie Hamilton is the administrator.

REBECCA McFADDEN: Okay. Sorry, Mark.

MARK SEDDON: No. It's still the same number, emergency number, in terms of reporting.

CYNTHIA BECKER: Yes.

MARK SEDDON: But then on the front end, which is the discipline part, so I'm trying to get a feel for liability. There's a comment in here, statement about if you employ an individual who's not certified. So does that mean that the facility is liable or is it the individual, like the employer, person?

JAMES FUTCH: Yeah. This practice act, this takes the lawyers a few moments to wrap their brain around it, because this practice act actually, we don't have the thing up anymore, when it looks at the discipline section, it actually grants the Department the authority to take action against the individual or the firm who employs them if they aren't certified.

So the authority over the, over the facility is strictly in the context of the rad tech statute, the Rad Tech Practice Act, is employing somebody who's not certified.

So let's say Leo goes into Florida Hospital. Took forever and a million years to do something like this. But Leo Bakersmith, one of our long-time inspectors, in checking the machine standards, in looking at the licensure of the folks coming in, if

you find somebody who's working, who's not certified, he's going to fill out a complaint form and that then goes back through our hands. That's going to result, same set of facts, is going to result in two complaints, basically. One against the facility for employing someone who's not certified to practice radiologic technology. And one against the unlicensed person, themselves. And there actually could possibly end up two different lawyers.

MARK SEDDON: Okay. So, like, how about an example. I know we've actually had this discussion in the past.

We have another, like a nurse, who's operating a CR in, like, a doctor's office.

JAMES FUTCH: There's three complaints. So there's one against the facility. Let's say the person is -- this honestly happened -- the unlicensed person is running the CR for the radiologist.

This isn't quite as clear-cut when it comes to the nurse because there's a cardiology exemption and we talked about this before. But it is certainly possible that another licensed person or another licensed individual, but there were four people

involved in doing whatever was happening. There could be multiple complaints and it's all going to end up in the pipeline that Lynne talked about. Going to the CSU part of MQA.

MARK SEDDON: Gotcha. Okay.

JAMES FUTCH: And what's going to happen is, if they're found to be legally sufficient, the ones that pertain to the technologists, they're going to come and be handled by, essentially, us.

The one that pertains to the licensed medical doctor, whoever he may be, that's going to end up with the Board of Medicine eventually. If it's legally sufficient, the Board of Medicine is going to act upon that like they would any other disciplinary matter for a licensed individual.

If it's anybody who's not licensed at all, there's a special attorney who just handles unlicensed activity. And so all the unlicensed cases are going to end up with her.

MARK SEDDON: Right. So any variation from the MQA for the technologists act, will actually branch out to all their -- all the other areas.

JAMES FUTCH: Mm-hmm. Medical physicists even has happened.

MARK SEDDON: Medical physicists, exactly, same

thing. For medical events, if there's a medical event that involves a physician having a -- you ask for a investigation, you report that to the medical board?

JAMES FUTCH: Well, we would report it to the same place.

MARK SEDDON: The same place and they would report to --

JAMES FUTCH: Right. So, obviously, we have actually submitted a couple of those in the past. I think at least one, maybe two medical physicists a couple times. A physician, I can't even remember why anymore. But something that was pretty egregious that happened.

So we do it this way. We fulfill, we being the Department of Radiation Control, we fulfill our responsibility because it originated in some of the areas where our inspectors, came to our knowledge somehow. So we fulfill our responsibility when that complaint is submitted to MQA and then it, it's -- we know it's never going to come back to us and it goes over to whatever part of the department that person is certified or licensed by.

Say it's a podiatrist, for example.

EFSTRATIOS LAGOUTARIS: Isn't it always?

(Laughter)

LYNNE ANDRESEN: James, I just want to add also, even anonymous complaints start out in CSU. So it's telephone, e-mails, zzz mail, they start out, that's the baseline of the complaints.

MARK SEDDON: And these can take, it looks like some of these take a very long time to come to any fruition.

JAMES FUTCH: Think of it as the criminal justice system only inside of administrative law. All the usual issues.

MARK SEDDON: So for the one example you guys have for the -- there was a medical event. The normal medical event, you said you're trying to get them completed within 15 days.

JAMES FUTCH: That's our part of it.

MARK SEDDON: Your part.

JAMES FUTCH: Yes. That's just getting the information. So what was the breakdown? Three percent are in CSU, 15 percent are in ISU. The vast majority are rare. Are with the lawyers.

LYNNE ANDRESEN: PSU. 60 percent. 60 percent.

GINNI SHAW: Those 15 days are just kind of on our side. We want to try to have it rolling on our side to hand over to them.

MARK SEDDON: Right.

GINNI SHAW: And then you guys get to us, your report within 15 days. Then we see you guys within 15 days. And then we try to generate the final report within 15 days. So 45 days altogether we're trying to get the report done and handled on our side and handed over to them is our goal is what we're going to try to do.

MARK SEDDON: Okay.

CLARK ELDREDGE: Well, actually, I would like to clarify. That was 15 days to draft.

MARK SEDDON: Right.

CLARK ELDREDGE: But then it has to go through James' hands and he's going to mark it up.

(Laughter)

JAMES FUTCH: Okay.

GINNI SHAW: Right. The draft report. Going for review, I guess I should say.

CLARK ELDREDGE: To be routed through the internal review process.

MARK SEDDON: Okay. Very good.

CHANTEL CORBETT: I'm sorry. You mentioned CPT license use. Okay. I didn't know.

JAMES FUTCH: Yeah. It would come together at the same time.

I'm just the guy turning the lights on. Who's next?

RANDY SCHENKMAN, CHAIRPERSON: Anybody have any more questions or comments?

Okay. We're going to skip ahead a little bit, if that's okay, and we're going to have Clark give --

CLARK ELDREDGE: I'm going to start -- take us to lunch and then I probably won't get through by then, but --

GINNI SHAW: Food for thought.

CLARK ELDREDGE: Yeah. Then we'll have Allen start after lunch to try to keep you awake after lunch and then you'll get back to me to put you to sleep.

The first thing I wanted to discuss is not in my slides or anything. It's the kind of question I want to make sure that we're all on the same page, right? And we all have the basic, what I think is a basic understanding about it. Radiation is hazardous. It does hurt people, right? It's a tool we've taken and we decided to use it because it provides us, for certain cases it provides us with -- in human, on human exposure, clarify that. It provides us medical information that can be used

to save a life, treat a life, prevent a disease, that the risk from the radiation is much less than the benefit we're getting to preserve and help peoples' lives, correct? I mean, that's -- it's a preventive, right?

So we have a case right now that we're beginning to pursue, of a facility that has been exposing people to diagnostic radiation services, but nothing's being done for medical purposes. So the person goes in. A doctor has actually written a prescription for this exposure. But there's no health care provided related to that radiation exposure. Nothing that is in that kind of definition.

They think there's -- they feel that there's a benefit there, but it is not -- what am I trying to say? It's not being used for the treatment, for the prevention or diagnosis of disease.

So if this scenario that we're pursuing, would you all agree, as a council, that's an appropriate thing for us to pursue and take administrative action against?

RANDY SCHENKMAN, CHAIRPERSON: What do they do? What are they using the radiation for?

STRATIS LAGOUTARIS: Does the doctor own the

machine?

REBECCA McFADDEN: We need an example.

CLARK ELDREDGE: The doctor does not own the machine. I'm trying to make sure -- they are measuring body fat index.

NICHOLAS PLAXTON: DexaScan.

RANDY SCHENKMAN, CHAIRPERSON: Oh, okay.

CLARK ELDREDGE: I'm not trying to use that word. That's why I'm trying to talk --

GINNI SHAW: So it's not being used in the x-ray and the healing arts.

CLARK ELDREDGE: Is not being used -- which actually is the first thing in my presentation is working on the definition of healing arts.

CHANTEL CORBETT: It's just being used for analysis.

CLARK ELDREDGE: No. The doctor writing the script, it never comes back to him. It's never reviewed by another licensed person.

GINNI SHAW: It's not generating a report and giving a diagnosis.

CLARK ELDREDGE: It's not generating a report.

CHANTEL CORBETT: It's got to be generating a report. Maybe not a written one, but somebody has got to be looking at the percentages because there's

no other point to doing it.

CLARK ELDREDGE: It may be an athletic trainer. It may be --

CHANTEL CORBETT: Right. That's what I'm saying. They're still getting data.

GINNI SHAW: Initially. I just mean --

CLARK ELDREDGE: But the whole purpose is that it's a medical professional.

CHANTEL CORBETT: So who's writing the scripts?

CLARK ELDREDGE: A physician somewhere licensed by the State of Florida. And this person has never put in their, as far as we can tell, is never actually put in as a patient of theirs.

Sounds vaguely familiar like certain other practices were dealing with pills down in south Florida at one point but, you know, where doctors were writing scripts without ever really seeing a patient or evaluating them.

MATTHEW WALSER: We talked about this a meeting or two ago. Are you talking specifically about a DEXA scan?

CLARK ELDREDGE: Okay. Yeah.

MATTHEW WALSER: I'll go ahead and say it. But I think, didn't we talk about this a couple meetings ago? It was kind of a new and upcoming thing?

REBECCA McFADDEN: We were looking at different ways that radiation was being utilized in airports and -- the sheriff's offices and jails, they were utilizing it there.

JAMES FUTCH: Okay. We definitely talked about security scanners.

REBECCA McFADDEN: Right.

JAMES FUTCH: We actually have a regulation in the Florida Administrative Code that's, that's based upon an ANSI, AAPM standard for that. But there's no physician ordering that.

CHANTEL CORBETT: So what's the State requirement for licensure? Is there one for operating a DexaScan?

JAMES FUTCH: For Dexa? For ionizing radiation?

GINNI SHAW: They do have technologists.

CLARK ELDREDGE: They've hired technologists to run the machine. The doctor has written a script saying give the person a Dexa. It sits there, per se. It's not being used, as I say for, for any --

MATTHEW WALSER: I just wonder if that individual takes that report to a nutritionist or a --

RANDY SCHENKMAN, CHAIRPERSON: Does it go some

place else?

MATTHEW WALSER: An athletic trainer or --

GINNI SHAW: The way that they advertise it on their site, they have a website and it's like -- can I say the name of the place?

JAMES FUTCH: No.

GINNI SHAW: It almost is advertised like a gym with personal trainers and those things. And so you just go in and they just offer this to you. So I don't know that you're even seeing a physician, period.

CHANTEL CORBETT: So as a "patient", though -- leave that in quotes -- patient getting this done, are you signing something saying you are being exposed to, you know, x-rays?

GINNI SHAW: I'm not sure. The site doesn't say that.

CHANTEL CORBETT: Because honestly, I think there's a break between, like, a legit physician ordering this to be done, and then it being recorded and billing on the backside. I see those maybe as separate things. Maybe that's just --

MATTHEW WALSER: For the health care of the patient, you know. But I think that -- I see where you guys are going. There is a doctor somewhere

that receives a name of a person that they've never seen. There's no medical chart. They write a script for a DEXA scan electronically. Probably goes directly to the facility. And the doctor probably has some kind of financial kickback for being the guy or girl.

WILLIAM ATHERTON: I'm curious as to who's paying for the scan because --

CLARK ELDREDGE: Well, the patient is paying about -- it's about 125 bucks or 80 with a Groupon.

MATTHEW WALSER: With a Groupon?

CLARK ELDREDGE: Groupon. Yeah, you know, and this is --

RANDY SCHENKMAN, CHAIRPERSON: So the patient is paying when they walk in.

CLARK ELDREDGE: When they walk in.

MATTHEW WALSER: Where you're treating somebody, where you're writing a prescription without having any kind of medical documentation.

CHANTEL CORBETT: And that's got to be determined, too. Because, I mean, as much as Kelly Health is a thing now.

MATTHEW WALSER: It's still on the chart.

CHANTEL CORBETT: No, I know. I'm not saying they even know at this point whether that's true.

You know, this person may be getting an electronic form of this patient.

CLARK ELDREDGE: The patient -- the individual does fill out a questionnaire.

CHANTEL CORBETT: Okay.

CLARK ELDREDGE: It's faxed in; it's faxed back.

CHANTEL CORBETT: Okay.

CLARK ELDREDGE: But at that point, the individual ordered the treatment and has not done anything with it.

JAMES FUTCH: So the results are not going back to the ordering physician?

CLARK ELDREDGE: They're not going back to the ordering physician.

JAMES FUTCH: What was written on the script for? What was it being ordered for?

CLARK ELDREDGE: Our inspectors never did provide that. Hopefully -- all they did in that inspection was, yes, they saw that the physician had written the script, but that the operator then said nope, nothing is done with it. It's not used in any way.

CHANTEL CORBETT: That can't be true.

CLARK ELDREDGE: Well, other than the operator

turns around and reviews it and says, you know, again, oh, well, here are the measurements. This is what they --

ADAM WEAVER: The operator is interpreting the data?

CLARK ELDREDGE: The operator -- according to the, yeah, the operator or some other person at the facility is interpreting for them. Or it's part of the package software.

WILLIAM ATHERTON: Well, the machine software will print it out.

CLARK ELDREDGE: The machine software just prints it out.

ADAM WEAVER: Right.

WILLIAM ATHERTON: They're just reading the English, whatever it says.

CHANTEL CORBETT: Right.

RANDY SCHENKMAN, CHAIRPERSON: But it's from a website you said that looks like a gym?

GINNI SHAW: The way that it is --

CHANTEL CORBETT: Probably is with body fat.

GINNI SHAW: The way it's portrayed, it's like a personal trainer.

RANDY SCHENKMAN, CHAIRPERSON: So the patient would take it to the -- wherever this facility for

the gym is or wherever the trainers are or whatever.

CLARK ELDREDGE: They are trying to put them in the gym.

RANDY SCHENKMAN, CHAIRPERSON: Yeah.

CLARK ELDREDGE: So you can get your weekly scan to see how cut you are in this arm versus that arm.

ADAM WEAVER: They do it weekly or do they have a set frequency?

CLARK ELDREDGE: A package of 12 for a year, you know, that --

CHANTEL CORBETT: What's the radiation?

WILLIAM ATHERTON: It may be related to some kind of kickback.

CLARK ELDREDGE: Well, ACR actually has their guidance for bone density and those uses and they list the long, five pages type thing that says, here's the appropriate use. And they've got a paragraph that says it can be used for flipping for body mass when you're dealing with, a list of specific digestive and metabolic diseases and the treatment of that. So there is that guidance out there for the appropriate use from ACR.

JAMES FUTCH: Yeah. If someone were to file a complaint against a physician along the lines of

what Lynne was talking about, for example, that's going to go to CSU. They're going to start looking for statutes under 458 if it's an MD and try and say, this looks like they're not doing that or something like that. You're going to have to have a fair, some amount of material to at least kind of give a hint that this is what it looks like it might be part of.

If they find that to be legally sufficient, they'll probably send it to ISU and ask for further investigation of the physician for, you know, whatever he's not doing under 458.

So it's going to come back to how much documentation and how much testimony do you have to show that he's writing a prescription for the treatment of, or at least for the, for an image or sort of analysis data to see if this particular bodily function is impaired so he can treat it. You're going to have to have something that shows that on the front end and then some testimony on the way through that shows that's not actually being done and something else was being done.

Like they decided, I don't know how to do this or what this is even for. But you -- what do you do with this information? Does anybody know what you

do with this information in the gymnasium?

NICHOLAS PLAXTON: You tell them to work out more.

CHANTEL CORBETT: Yeah. It's to analyze your progress.

CLARK ELDREDGE: Well, the thing about it is, for body mass, this is my kind of what's the point. What's the practical point, I guess is the question.

Is that if we're talking about that type of body mass thing, you know. First of all, you go to your physician. He's going to look at you and say, you need to lose five pounds. There's nothing magic about that. It doesn't take radiation.

If, you know, there's the eggs for air displacement, there's the water tanks for water displacement and they are accurate within three percent or something like that and their whole buoyant about this thing, it's accurate to like one and a half percent. So the benefit of getting that extra percentage versus another technology that does not expose you to radiation, kind of that's where I look and see that it kind of defeats the whole purpose of the benefit of the information, the cost of the risk, the radiation, versus also the fact that in our codes, it says in 502 -- in 502, 5.502,

it does state that as prescribed by a physician and for the purposes of the healing arts. So it actually says -- it's a requirement for use of radiation machines on humans. It has to be for that.

Now, you know --

JAMES FUTCH: Usually we stop at the point where the doctor writes the prescription.

CLARK ELDREDGE: But before, it's been in a doctor's office. And this is not in anywhere a facility that is any related to a diagnostic center or doctor's office. In fact, the letters we have issued requesting clarification to the facility requesting the registration, has been, you're not a doctor's office, you're not a diagnostic, you're not this sort of health care facility. How are you using this for the healing arts?

ADAM WEAVER: How did you classify the x-ray facility? The doctor's office? How did you --

CLARK ELDREDGE: They applied as a doctor's office. They applied for MD.

GINNI SHAW: That's where we stopped. They applied and we're --

CLARK ELDREDGE: We had two that were -- there were two of these facilities registered prior to

recognizing the issue. And then there's one more that's requested to be registered. And so, the two that are currently registered, we've sent a letter saying, after audit of your inspection, we noticed that you didn't explain -- that there's no evidence, your own statements were that you're not doing anything for the healing arts. Please tell us why.

And then the other one that was applying, we've said, we see it's not one of these type facilities. Tell us how this is going to work. How you're going to be using this for medical treatment. And those were mailed out earlier this month. So it hasn't been 30 days yet for them to reply.

JAMES FUTCH: Have we talked to the manufacturer of the device?

CLARK ELDREDGE: GE? You know --

JAMES FUTCH: I'm just curious what they're saying.

WILLIAM ATHERTON: To make it a little more complicated, there was -- we had a presentation, I don't know, a couple meetings back, there was a special petition that jails got to have radiation without any medical purpose whatsoever.

CLARK ELDREDGE: We did give them an exemption from -- although, if you think about, they're

actually doing diagnostic, energy type exposures. There are, again, limits on the total radiation dose they can give the people. I would almost think somebody can probably sit down and do a cost benefit analysis for the fact that the guys, how many people might die in the jail for whatever they're trying to smuggle in, verses the risk of the individual getting radiation, you know.

WILLIAM ATHERTON: Well, that might be true, but I also think that, that sounds more dangerous to me than the DEXA scan, although I understand.

CLARK ELDREDGE: Yeah.

CHANTEL CORBETT: Do you know what the radiation is for the 12 scans? Let's say they get all 12 in the year.

CLARK ELDREDGE: I can't tell you off the top of my head, no.

JAMES FUTCH: We've done it before.

ADAM WEAVER: A whole body DexaScan is probably around 40 --

CLARK ELDREDGE: Yeah, it is small. In fact, that's one of the sales --

MARK SEDDON: It's real small.

CHANTEL CORBETT: It's for a member of the public.

ADAM WEAVER: Well, that's per scan.
CLARK ELDREDGE: Per scan, but again --
ADAM WEAVER: If you're doing the whole body, assuming it's a dual energy machine.
CLARK ELDREDGE: At the same point, you know, the codes basically say, without healing arts purposes.
CHANTEL CORBETT: Healing arts, I mean, is that defined as --
CLARK ELDREDGE: Well, we might as go ahead and -- well, let's start with, let's start the first one, shall we?
JAMES FUTCH: Have you caused enough mayhem yet for us to move to the next part?
Seriously, do you want to, like, invite a manufacturer to come in and talk to the Council later on and try to answer these questions?
CLARK ELDREDGE: We could.
ADAM WEAVER: They are the ones who write the programs for these machines.
JAMES FUTCH: Do you want the Power Point?
CLARK ELDREDGE: Yeah. Go ahead and open it.
I will apologize for this Power Point. I was going to hand out printouts so there would be something for you to read in front of you and look

at. The 30 copies are sitting in the printer back at the office and so, this is going to be really ugly for parts of this. But so, I'll have, the outline of this is -- these are all discussion topics. So I'll introduce what I want to talk about. I will put a little bit of language that we're considering and we all get to discuss with that, things like:

Are we completely off base? This is not something we need to worry about. Is this something you would like to prefer us to go back and research more? Is this something, if you actually want to take a vote and say, yeah, this is a great idea. Take this forward and try to clean it up or whatever rule.

So healing arts. An issue about harm to patients and what that means. Vendor registration. Something on actual authorizations for therapy. Therapy authorization for the therapy machines.

Particle therapy. Taking pictures with radiograph with x-rays versus just doing an analysis of the material. Systems that are going to be modified outside of what was originally designed and changes in technology, which kind of over compasses a lot of what we're talking.

We have a problem that -- we actually have an issue with going both through the statutes in search of the rules, nobody ever has defined what healing arts are. In Florida Statutes, it's referred to in -- the phrase "healing arts" is used to describe what types of medications and materials might be reimbursed for insurance or over the counter, some of that type of stuff. Various standards for how payments and things are done. What requires a prescription or not.

It's used -- it's not acupuncture, but come on. I'm trying to say the word. Hypnosis. There's actually something that hypnosis and other sections where it says when working with a practitioner, when it can be used with a working practitioner for healing arts. And then in our codes, we use this phrase "healing arts". About the healing arts self-referral.

Why people aren't supposed to be, you know, in this case, where you can't go and ask for an x-ray without a doctor determining that it's for your health benefit. Except for people that go out and do a self-referral for mammo.

So I would propose that we actually add under -- into the definitions in our codes, a

definition of healing arts, that it's the practice of a licensed practitioner as defined under these sections. And these are actually the lists of osteopath, medical physician, PA, the folks who are currently recognized as being able to order, handle diagnostic, diagnostic tests. And then 446 is the dentists because they have to be able to use it in their practice for taking x-rays of the jaw and the teeth.

And so basically, this would clear up the question that -- it's actually trying to clear up the fact that we consider healing arts actually the prevention, treatment -- purpose of diagnosis and treatment of disease. There's actually a definite medical component and clear up this type of feedback on the bone density.

Do you all have --

RANDY SCHENKMAN, CHAIRPERSON: Anybody have any comments?

CLARK ELDREDGE: Comments, discussion.

CHANTEL CORBETT: Playing Devil's advocate, I mean, if you're saying prevention of disease, obesity is considered a disease, so --

CLARK ELDREDGE: But it's also under the practice of licensed practitioner ordered it --

CHANTEL CORBETT: You're saying a doctor's order again.

CLARK ELDREDGE: Yeah, but they are not reviewing it and offer any prescriptive device. It's the practice of a licensed practitioner, but practice is reviewing the medical charts --

CHANTEL CORBETT: Right, which we don't know if they're doing.

CLARK ELDREDGE: Right. And working with the patient for 125 bucks.

NICHOLAS PLAXTON: They could be -- I mean, I don't know the whole situation, but they could be taking this questionnaire and ordering it. Then maybe they're getting the, it's just a number that's coming back. Maybe they review the numbers and flag which ones are abnormal. It's hard to say. I mean, I don't know. But I can see them fitting into this definition.

CLARK ELDREDGE: Well, if they are doing that, that's fine.

NICHOLAS PLAXTON: Yeah, that's what I'm saying. Are they doing it?

CLARK ELDREDGE: The point is if they're not. If the doctor is doing that and they're actually thinking it's appropriate for the person, but

that's -- but anyway, but the idea here is that there is no definition of healing arts.

KATHY DROTAR: Clark, are you also saying that it not just about ordering it, but that the treatment that's ordered after is being ordered by a physician as well, because that's what we're designated as medical treatment as opposed to somebody reading a paper and saying, well, this is what it is.

CLARK ELDREDGE: Treatment, right.

KATHY DROTAR: Now, if they have a protocol that the doctor's given them for, for a specific, but we don't know any of that information, so I think it's hard to go back and, you know, just add in what we all think might be happening without having the facts there.

CLARK ELDREDGE: Well, the thing is, this is to establish the standard of how we want to evaluate it. Okay? The fact that this is not so much to, if there's a problem or not, but to make sure if we -- if a problem does present itself, that we have a standard that we believe is appropriate for evaluating the situation. And that we're not going off and doing something inappropriate. And so, that's what the purpose of adding a definition of

healing arts. That it is actually the practice of providing medical care, the continuum.

KATHY DROTAR: Continuum.

CLARK ELDREDGE: The continuum of care as people are doing under their licenses.

KATHY DROTAR: For the real purpose that the exam was ordered for and still under the physician's care.

CLARK ELDREDGE: Care. And that's just the whole --

KATHY DROTAR: Whoever.

CLARK ELDREDGE: So this is, this basically establishes the standard at which we have to evaluate something.

MARK SEDDON: So the licensed practitioner --

ADAM WEAVER: This is just for x-ray machines? Is this for --

CLARK ELDREDGE: This would be for any, any, this is all of radiation, basically.

ADAM WEAVER: Is it used for ultrasound?

CLARK ELDREDGE: No, no, this is only under BRC, only under ionizing radiation.

ADAM WEAVER: Okay.

CLARK ELDREDGE: Because again, we have no authority to put a rule anywhere else. This would

go into our sections of the rules because no where else in any rule or statute has anybody defined it. They've used the phrase repeatedly in statute and in rules --

ADAM WEAVER: Mm-hmm.

CLARK ELDREDGE: -- but they never defined what it was. So for the scope of exposing somebody to ionizing radiation, we think that --

ADAM WEAVER: You think that's language that you need to put that in here, that this is only concerning ionizing radiation?

CLARK ELDREDGE: It would be in our rules. This would be a --

ADAM WEAVER: This would be part of the --

RANDY SCHENKMAN, CHAIRPERSON: So part of those, each of those sections, it has that written out?

CLARK ELDREDGE: Right. Well, those sections define who the practitioners of healing arts are.

MARK SEDDON: That's pretty broad, isn't it? I mean, it encompasses a lot.

CLARK ELDREDGE: It encompasses a lot and that's fine. These are already the people that we've accepted as doing radiation, providing --

MARK SEDDON: But those licensed practitioners

are not defined from Bureau of Radiation Control, but actually, that's just Florida Statute in general, correct?

CLARK ELDREDGE: Right. These are the people who we accept as practitioners.

MARK SEDDON: Yeah. So that could still be changed by other professions.

CLARK ELDREDGE: Other professions. Under the statute. It could be defined by the statute, but that's a legislative and our government, that's the prerogative.

MARK SEDDON: They put chiropractic --

CLARK ELDREDGE: The chiropractics in there.

MARK SEDDON: Dentistry.

CLARK ELDREDGE: Yeah, actually, dentistry was 446. And that's where the licensed practice for dentistry, that's that section. All the other ones list the chiropractics, the osteopaths, the naturopaths, the whole -- the standard group of people that are currently, considered as licensed practitioners for medical care in the State of Florida.

JAMES FUTCH: So --

STRATIS LAGOUTARIS: I just have a question. Forgive me if it doesn't make any sense.

Is it so broad of a statement that it would give someone like myself, the podiatrist, the authority to order a DexaScan on a patient and that I'm not treating necessarily their foot or ankle?

CLARK ELDREDGE: No, but this again, incorporates your, your licensed practice thing. So no, it doesn't -- this is outside. You would still be limited by your practice standards.

STRATIS LAGOUTARIS: Okay.

CLARK ELDREDGE: I mean, this is not too broad. This says the various physician categories -- I'll use that term physician broadly in this case. Medical professionals. Medical practitioners, excuse me. This is the broad list of those, and they are still limited by their standards of practice.

STRATIS LAGOUTARIS: Thank you.

JAMES FUTCH: Could I say one thing?

CLARK ELDREDGE: Yeah, please.

JAMES FUTCH: So the definition you guys are seeing, 468.3101(m) is licensed practitioner as defined in the rad tech statutes, which is very broad. And it includes everything that we all think of as physician. It could also, has been construed to include physician assistant and nurse

practitioner working underneath the appropriate supervision of those individuals. Although it doesn't explicitly say that.

And then the dentist is the 466 tie in?

CLARK ELDREDGE: 466 is the dentist, yes.

JAMES FUTCH: So all of those things are defined in the statute, which is why Clark, I think, is referring to them.

CLARK ELDREDGE: I'm referring to them because are these statutory definitions.

JAMES FUTCH: Right. They are already tied into some part of the use of ionizing radiation. Mostly through my statute. And these are -- there's no, nothing in 404? That's even close?

CLARK ELDREDGE: No.

JAMES FUTCH: Which is kind of odd.

CLARK ELDREDGE: Yeah. That's why I had to go to -- and so that, it's just that, all these people on that list are covered by their practice standards as handled by their boards, et cetera, et cetera.

ADAM WEAVER: Where are you planning to add this definition?

CLARK ELDREDGE: To 64E-5.101, the definition sections.

JAMES FUTCH: So Clark, in his statute, in his

enabling statute 404, is the phrase healing arts used somewhere?

CLARK ELDREDGE: We use it in code. It's not in --

JAMES FUTCH: Is there anything in the statute that you can hang this on? That's close to this?

CLARK ELDREDGE: That's the whole problem. There's no definition of healing arts in statute. They refer to healing arts in several statutes throughout -- if you go to our wonderful legislative website and search for healing arts. But that's the reason for adding one to our statute, to clarify what exactly it is we're envisioning when you say as prescribed by a physician and for the purpose, as a licensed practitioner, and for the purposes of healing arts, we need to know what those arts are. And those arts are the practice bound by -- there's practice standards. And this is just pulling back into the practice standards. So if a physician is actually ordering an x-ray, that it is for the purpose of -- he's doing, he's going to do something with that result that falls within the practice standards.

Because right now, you know, healing arts may be, you know, with no clear definition, it would be

what the lawyers want to argue it is versus the fact that it's supposed to be construed, limited -- I think the intent is to limit within the practice standards as done by the boards.

ADAM WEAVER: Have you shown this to your lawyers yet?

CLARK ELDREDGE: We've discussed it with them but not shown it to them, no.

MARK SEDDON: Do physical therapists have -- are they considered licensed practitioners?

CLARK ELDREDGE: Not under the rad tech section.

ADAM WEAVER: Not for ionizing radiation.

NICHOLAS PLAXTON: What about nurse practitioners? I know they now have authority to do things on their own outside of physicians. Is that --

CHANTEL CORBETT: That's under the current.

NICHOLAS PLAXTON: The latest was allowing them to do things outside.

CLARK ELDREDGE: What level? That's updated. It would have to be updated, it would have to be updated within the rad, rad section for it to go into effect here. So this is strictly a --

RANDY SCHENKMAN, CHAIRPERSON: We were just

discussing how this Section 468.301, whatever, what's stated in there that would, along with this statement, prevent someone like this doctor from doing what he's doing.

CLARK ELDREDGE: It would actually turn around. It would go back to the practice standards. And whether or not what he's doing with the medical treatment is within practice standards.

And I'm not saying whether or not our friends down the hall are actually investigating this, since we're talking with them on this case. But it would be a lot, part of the restriction on the -- in the case that we discussed earlier with the body fat monitoring, it would be somewhat dependent on us working with them to determine that the -- that it is a violation of the practice standards that --

RANDY SCHENKMAN, CHAIRPERSON: Do the practice standards say anything about if a physician orders a study, they have to review the results?

CLARK ELDREDGE: That's -- I can't answer that. That's what -- we're working with them on that.

CHANTEL CORBETT: Just in regular medicine, you have physicians all the time who order a test to be done and then those results don't necessarily -- I mean, you can go for a follow up with that same

physician's office months later and somebody else reads it and they've never even seen the results. So --

ADAM WEAVER: They just read the report.

CHANTEL CORBETT: Right. They will eventually call for it maybe, but they don't automatically get it.

ADAM WEAVER: Or the summary or the conclusion. Something like that.

CHANTEL CORBETT: So it may be the same thing. I mean, the doctor could call and get the result for anybody.

MARK SEDDON: Or their partner is reading it.

CHANTEL CORBETT: Right. There's nine million ways --

MARK SEDDON: Happens a lot in cardiology offices where one person reads a nuclear stress test.

CHANTEL CORBETT: They go into the hospital and they don't read it at all.

MARK SEDDON: And somebody else actually follows that patient.

CHANTEL CORBETT: Right.

MATTHEW WALSER: I think the big thing for these guys, is there an actual medical record for

each patient that this person is prescribing a scan for, is there an electronic medical record or file, somewhere in the file cabinet in somebody's office that --

CHANTEL CORBETT: With the results.

MATTHEW WALSER: Yes. With names, date of birth, all of that, the questionnaire form. You know, is there an actual file. Because that is in the Medical Practice Act.

CLARK ELDREDGE: Exactly.

CHANTEL CORBETT: I mean, all gyms in the old days, when you did any other kind of body fat thing, you know, you had your whole list of your progress. So I would, I would assume that --

CLARK ELDREDGE: But that was the gyms and your trainers. That wasn't a physician who was monitoring. It was part --

CHANTEL CORBETT: That's what I'm saying. The monitoring is no part of this. The way it's written. But it's saying to order it.

KATHY DROTAR: Isn't that -- doesn't that really go back to, like, a medical practice issue as opposed to the radiation event?

CHANTEL CORBETT: Right.

KATHY DROTAR: And, you know, everybody meeting

the other requirements that would be necessary for, is there a radiation control plan or safety plan or are they doing things that are within the correct parameters as far as the radiation goes?

ALLEN MOODY: That was my question, too. Isn't there -- is there no requirement that they track those doses received and be able to --

CLARK ELDREDGE: In Florida, the physician decides what's the appropriate dose for his patient.

ALLEN MOODY: But I mean, when your guy who's writing it for the gym says, okay, you can have this, but there's -- is it an open-ended thing or is it --

CLARK ELDREDGE: It's open ended. There's nothing in our -- it's up to the -- again, but if the physician's not considering that, that very well could be a --

CHANTEL CORBETT: Is this a script for a one-time thing or is it a script for 12 in a year?

MATTHEW WALSER: The Groupon that I just found was one time for $102.

CLARK ELDREDGE: Yeah. And to be a little bit --

MATTHEW WALSER: The gym right over here.

CLARK ELDREDGE: What does a doctor do for 102

bucks?

MATTHEW WALSER: Write a prescription.

CHANTEL CORBETT: Probably more than he does at a walk-in clinic.

WILLIAM ATHERTON: If it's an issue, won't it eventually go back to the medical board of that practitioner?

CLARK ELDREDGE: Right.

WILLIAM ATHERTON: Why don't you give it to them and make them tell them to --

CLARK ELDREDGE: There's two parts here. Again, it's our machine part and whether the people should be permitted to use -- have the machine at that location operating, expose humans to it. And our codes --

CHANTEL CORBETT: They applied for these licenses or registrations for the x-ray. They've already got two that are registered. So obviously, they submitted the proper documentation.

CLARK ELDREDGE: Well, two were registered without anyone there -- when, you know, you assumed things certain, when paperwork comes in, that people are agreeing to follow the codes and rules. When you --

CHANTEL CORBETT: Right. You're saying they

have a registered technologist working the machine and you're saying that there's a physician ordering the test.

CLARK ELDREDGE: But again, the code requires also for the purposes of the healing arts. And that's the question we're asking at this point is --

CHANTEL CORBETT: As you've already said, there's no definition for that. So you can't say you're going against the definition because there is none.

CLARK ELDREDGE: Well, we can ask them how they're doing it and see what they say.

KATHY DROTAR: Who's going to make the decision that it's not for healing --

CHANTEL CORBETT: Right.

KATHY DROTAR: No matter what kind of definition you put on it.

MARK SEDDON: Right. Like those medical cosmetic clinics that have lasers for veins, quote, the doctor owns it, but then, it's really just for, you know, cosmetics. So how is that -- I mean, it's similar type as this. Like, that's not really healing arts, but it's still medical procedures being done. Botox.

NICHOLAS PLAXTON: You can consider it healing

arts because the patients feel better, they cosmetically look better.

CHANTEL CORBETT: And for varicose veins.

NICHOLAS PLAXTON: Yeah.

RANDY SCHENKMAN, CHAIRPERSON: Just to let you all know, lunch is ready. So I don't know whether -- I'm not sure exactly what you want us to do with this, Clark. Is it just to get our input or what?

CLARK ELDREDGE: It's -- okay. The language sections here, I gather I want to hear, I guess the question I would ask the council is one of three things:

If, you know, does anybody think this is -- does the council feel that this is ready for prime time to proceed? Is there any suggestions that you think we need to go work on more, or that's interesting and we'll think about it later. Sort of, you know, if you all are motivated enough to offer a formal opinion, we'd be happy to have one.

So does anybody want --

ADAM WEAVER: Can I ask one question? Have you compared notes with any other states through, like your CRCPD? Because I know this isn't unique to Florida. I think it started in California. So have

you checked to see what other states --

CLARK ELDREDGE: The states that have this doesn't have any regs that don't -- it doesn't reflect it. They have no authority.

ADAM WEAVER: Do they have any comments in regard to -- the risk that the patients are, are being exposed to, which is --

CLARK ELDREDGE: I have no -- I do not have any, shall I say, numerical data that I can provide on that. And I don't think it's necessarily appropriate to -- the anecdotal stuff from the conference calls, I don't think is --

ADAM WEAVER: Okay.

CYNTHIA BECKER: Other than we know other states are wondering or considering how to also license these facilities or register these facilities. And the issues are out there. Just like they were with security scanners when we started on that a few years ago, so --

CLARK ELDREDGE: The comments range from -- well, the comments have ranged from -- I guess I am speaking in anecdotal this time. From we have no authority or no way to regulate, to it's a bad idea type thing, as opposed to, there was no --

CYNTHIA BECKER: Right. You're going to have

states that say we don't allow it. We don't want to allow it or we didn't even know it exists. I've heard that, too. So --

ADAM WEAVER: Right.

CYNTHIA BECKER: We should find out more next week -- this week.

GINNI SHAW: I can pick peoples' brains next week at CRCPD.

ALLEN MOODY: It's just hard for me to believe that a physician, quote unquote, who orders some radiotherapy is not required to track a patient's dose.

NICHOLAS PLAXTON: It's not therapy.

WILLIAM ATHERTON: It's not therapy.

RANDY SCHENKMAN, CHAIRPERSON: It's diagnostic.

ALLEN MOODY: You know.

GINNI SHAW: It's diagnostic. To be honest, it is low dose.

ADAM WEAVER: It's more than the inmates are getting, but not that much more.

ALLEN MOODY: I wasn't thinking about that. I was thinking about your guy with the, using it for the muscle mass. Reducing muscle mass. That would be, to me that would seem like it would fall under some kind of, under supposed therapeutic usage.

CHANTEL CORBETT: It's not increasing. It's just analyzing.

ADAM WEAVER: Just analyzing the data.

RANDY SCHENKMAN, CHAIRPERSON: Well, do we want to approve this or do we want to have further discussion?

KATHY DROTAR: Further discussion.

ADAM WEAVER: Further discussion.

CLARK ELDREDGE: Okay.

RANDY SCHENKMAN, CHAIRPERSON: All in favor of further discussion, say aye.

COUNCIL MEMBERS: Aye.

RANDY SCHENKMAN, CHAIRPERSON: Opposed?

(No response)

RANDY SCHENKMAN, CHAIRPERSON: Okay. So we will continue this.

CLARK ELDREDGE: All right. After Allen's presentation after lunch.

DOUGLASS COOKE: On your way out, everyone's food is already prepared. If you'll walk to the register, pay for your lunch and then sit down and they will bring it to you as soon as you're seated. Okay? Thank you all very much.

(Proceedings recessed at 12:10 p.m.)

(Proceedings resumed at 1:32 p.m.)

RANDY SCHENKMAN, CHAIRPERSON: So we're going to continue on with the agenda as it was originally.

BRENDA ANDREWS: All right, everybody. Convene, everybody.

JAMES FUTCH: I know it's after lunch. We're going to turn the lights down.

RANDY SCHENKMAN, CHAIRPERSON: So we're up to Allen.

JAMES FUTCH: Cindy, do you want to introduce him?

CINDY BECKER: Introduce him, yes. Okay. So this is Allen Moody. He's our chemist administrator. He has been with us a very long time and exited for a very short time and then came back with us for a very long time again. That's because he loves us so.

ALLEN MOODY: It must have been something like that, yes.

CINDY BECKER: And I'm hoping we can also talk you into some time doing this presentation with other organizations.

ALLEN MOODY: Right. Well, I was saying I'm going to go on the road with this. Apparently, it's a bit hit. It debuted at the Health Physics Society meeting a little while, when was that? About --

BRENDA ANDREWS: April 6.

ADAM WEAVER: April.

ALLEN MOODY: Apparently, it was a big hit, so this is the -- an encore performance. Like I said, we may go on the road with this at the rate this is going.

Now, this is one of the more -- I said at the Health Physics meeting that, you know, you talk about Florida and peoples say that Florida is full of bizarre people doing bizarre things and unfortunately, this is a prime example of it.

But, this, I got involved with this back in the summer of 2017. After -- when this person's materials had been basically temporarily confiscated by one of our -- by our field person, Kelly Anderson. And I'll talk a little bit about more about what went on from there.

But I introduced the gentleman without names -- without a name. He is a retiree living in Florida. He has a hobby. His hobby is he is an element collector. He wants to collect all the elements in the periodic table, which includes, of course, the radioactive ones. Apparently, there are others out there like him, which can be kind of a scary thought. Because there -- you will see that there's

actually, apparently, a market for this material, too, that I was not even aware existed.

He's an amateur experimenter. We'll have more on that later. And he managed to combine these two interests with a profit motive and became an entrepreneur selling stable elements and homemade radioactive compounds on EBay.

He buys uranium and thorium and the elements and some of the compounds from commercial suppliers in the U.S., though he says he's purchased thorium from China as well. He's purchased quite a bit of counting equipment. I'll have some slides on that. Also on EBay. He said that sometimes universities surplus these things without even knowing what they're really for. He says he can repair this equipment, too.

He has acids and a few simple chemicals, but he doesn't seem to be familiar with some basic chemical separation tools. If you're going to do radionuclide studies, that's basically what I do, you have to have certain -- have anti and cation resins for doing chemical separations and he doesn't seem to -- he didn't seem to be at all familiar with that. Or with very -- or with liquid extraction, which is another method that's sometimes used to

separate radionuclides. So his ability to do actual separation, chemical separations is very limited. So I'll have a little bit more about that.

He's got an extensive library of books on radiochemistry, though some are pretty old.

He sells -- he was selling stable elements, certain stable elements, but hazardous elements like sodium and phosphorus. I mean, sodium is a fire hazard if it's exposed to water and phosphorus is a fire hazard if it's exposed to air and it's just chemically toxic. But those elements EBay would no longer let him sell. They basically told him he could no longer sell those. But they did allow him to continue selling the uranium and thorium compounds.

He says he does not sell internationally and requires a driver's license, but otherwise doesn't restrict his sales.

He came to our attention and the attention of the NRC and the Florida Department of Health Bureau of Radiation Control for manufacturing what's called AM/BE neutron sources. They're americium and beryllium sources for creating neutrons. He claims he never sold of the AM/BE sources, but he said he loaned one to someone.

ADAM WEAVER: Not me.

ALLEN MOODY: His lab seems to be a free-standing garage apartment. We speculated maybe his wife won't let him do it in the house. It's actually, his residence sits up a hill from where his garage apartment laboratory is.

The radiation level in his, in his lab is about eight times background with no samples open. I want to make a parenthetical note here that at the time we measured that, we basically were returning his stuff. This was, his stuff, 107 samples from his laboratory were -- had been out of his house from about, I think July or August when this was first taken out, until we returned it in November. So basically, a lot of, a lot of his material had been taken out of there and presumably that -- they had several months for the radiation level to go down in there. And so we walk in there, Matt Sinison with me. He took radiation readings. On a background of about three MicroR, we're getting 24 in the place. And this, remember again, a lot of the radioactive materials were actually not in the place at the time. They were all sitting out in the car that we brought back -- brought down there to return his stuff.

He says he sells -- sales were about $1500 to $2000 a month, which is not bad for, I guess for a retiree.

Much of what he sells, including his homemade compounds, is packaged in small screwtop vials with neatly printed labels, though sometimes he uses septum vials for some reason. I guess convenience. I've got pictures of this.

Just handling his vials without opening them, we needed to take weights and do qualitative identifications, left me with significant contamination on my gloves, which I think is probably radon. We actually did -- had Matt taking swipes of the area, my work area, and he was not picking up anything. So whatever was there was either not surface contamination or it was very short lived. So presumably, we're talking about mostly radon contamination in the area.

To his credit, with rare exceptions, his compounds and materials seem to contain the nuclides advertised. We actually used an Ortec germanium detector to do qualitative and I.D.'s on all this stuff and with a very few exceptions, it all seems to be pretty much what he says it is.

This is his glove box, which he's manufactured

out of, I guess out of leucite. His glove ports are just slits cut into a rubber membrane. His hose, his exhaust hose from the glove box exhausts to his kitchen stove. It really does. I'll show you where it connects, actually. And he's actually pretty proud of this.

You know, I worked in Los Alamos. He basically wanted me to compare that to -- I didn't want to go there.

This is his lab bench top or -- which is his stove. And this is -- that's the exhaust from his stove is where he plugs in his, quote unquote, glove box hose goes up there. You can see he's got a balance, he's got a little microscope. He's got his other little -- his other tools that he uses. We've got more pictures of his work area in greater detail that are in the supplemental photos.

His safety equipment is just dust masks. And they're not fitted masks. They're not -- actual respirators have to be form fitted. And what he's got are just basically dust masks.

His counting equipment has got quite a bit of stuff, including a germanium detector, which shocked me because you have to have liquid nitrogen for those. You have to have a supply of liquid

nitrogen, but he says he gets it. That Dewar down there is, I recognize that is for a germanium detector, which is high-resolution gamma.

I guess you really can find a lot of things on EBay. He's mostly geared for gamma spectroscopy. He doesn't really have any equipment for alpha spec, but he does have quite a bit of stuff for gamma.

Where we came into this, we received 107 tagged samples of his material from our incident response coordinator Kelly Anderson, who also photographed them. Most of the photographs here are hers. Some sample bags contained multiple small vials. You'll see that.

We did nuclide identifications with an Ortec portable high purity germanium. It's a state-of-the-art field instrument, but I'm going to show you how that even can mislead you. We weighed the vials without opening them. We did not want that stuff contaminating our laboratory.

Where empty vials of his existed, we were able to estimate a net weight of the contents in the vials by subtracting the weight of the empty vials. We had comparable size of empty vials.

Where we had a good estimate of the net weights of the contents, we used his chemical assessment of

the compound. We took his word as to what it was, plus with the qualitative identification from the Ortec. The stoichiometry or the chemical composition was expected and the specific activity of each nuclide to determine an absolute activity. And the following slides are some of the material we got.

This was originally identified by Kelly, using Ortec as highly enriched germanium. It's not. The gentleman said -- it is, in fact, a glow-in-the-dark button for military uniforms from World War II. It's radium 226.

From the purpose -- for gamma identification, radium 226 has a 186 keV energy line. Uranium 235, which is highly enriched uranium, also has a 186 keV energy line. Even a germanium can't really tell the difference or we can tell the difference with very -- with great difficulty because the resolution on these systems is typically about one kilo electronvolt and the energy difference between the Uranium 235 and radium 226 is actually point seven so you usually can't even tell the difference with the -- between these.

As far as the Ortec goes, if you actually held this material in front of the Ortec a little longer,

the radium 226 identification would pop up on it. But if you just did a quick, put it in front of it, it identified it as HEU. So that's one of the things about using instrumentation. You have to be careful about and use all the available information that you have; consider the context of the material. You know, this is sort of the lesson that, lessons learned I think that might be useful in terms of -- in doing field identifications, too. You always -- if you have anything, any information that might be pertinent, then please consider it when you -- don't just take the instrument's word for what it says it is.

And also, it did say note the cute cow can. He has the most entertaining containers. Seriously. And there's another one.

I said the double ring purpose here, this one does not normally expect to find americium, which is itself repurposed from smoke detectors in one's tea tin, but that's some of the metal pieces glued on the disks, the arrow, turned out to be.

We did -- we didn't give him back his americium. We could keep that under law, because you could not -- you can't repurpose americium from smoke detectors.

By the way, the smoke detectors, I was pretty amazed. He had industrial smoke detectors, not the little units that were typical in houses. The industrial ones had about 80 microcuries per detector. Which we actually gave him back his intact ones because we couldn't keep them because he had not repurposed them yet. So we had to give those back to him.

This is a little bit of a quality control issue. Remember, I said she had taken several, she had grouped these into terms of what they, what they were -- he had identified them as. And so these are all supposed to be ammonium diuranate. You can see the colors are a little bit variable. Going from yellow to basically red orange. So he's -- he does have a little problem in terms of quality control.

These are labeled uranium hydride. They look homemade, and from what he told me, they are. So -- and, yes, he was combining uranium metal and hydrogen gas under heat. He did seem to know that you do not do this with any air present in there. He understood this. But, you know, it's still something that is a little bit alarming.

This one, he was trying to create, he was trying to get Protactinium 231, which is, I believe,

a uranium 235 daughter, to chemically deposit on the metal strip. He had his doubts that it had worked. And, in fact, we did gamma spectroscopy and were not able to detect protactinium positively in it. It has, like, three energy lines and at least one of those were not there. So we were not able to, we weren't able to really positively I.D. protactinium in there.

And this one, he had on the, on the label, he says neptunium -- neptunium and then AM 241, the arrow to Neptunium 237. It read on gamma as pretty much pure americium. It's about one microcurie there.

Remember, he can't really do chemical separations and so, there's going to be some Neptunium 237 there because it's an americium 241 daughter. But mostly what's there is americium 241.

This one -- so I've been to labs where they wouldn't let you open something like this except in a glove box. A real glove box. Not one of his. It contains fine black uranium oxide powder. Very easily disbursable stuff. When I opened this container, I thought, well, maybe there was a smaller container inside. Nope. You opened it up and there's the fine powder there.

And sometimes he's just not sure. And when he wasn't sure, sometimes he had this neatly printed label that said "unknown compound". Like I said, to me that seems like an oxymoron. To have a neatly printed label that says unknown compound, but that's what he did.

Anyway, he had this neatly printed label saying unknown compound. Sometimes when he didn't know, he didn't bother with a label and just wrote on there, okay, what it might be with a question mark on it.

So this is what we did. So under the law, americium 241 cannot be repurposed. So the Americium 241 we removed from smoke detectors, which I said again, they're 80 microcurie commercial smoke detectors. Were industrial detectors. Were retained by BRC. Which amounted to about, nine samples. We had -- we kept nine of them. One of which was weirdly, just seemed like fasteners. Little screws. But it read as AM 241, so we held on to it.

So his Pentek detectors were returned. This means we also retained the AM/BE sources he had which contained toxic beryllium powder, which is so weird, because I expected he would use beryllium foil. It wasn't foil. It was powder.

He was not over the legal quantity for natural uranium or thorium, so all of his uranium and thorium metal and compounds were also returned.

He told me the stories behind some of the number of his items. He's very enthusiastic about this. He has a story for almost everything that he created.

He was advised to consider not just his own safety but the safety of those who purchased his material, which I can do. I can tell him, look, consider the health of other people. And I asked him about himself and his attitude was, he's an old, like, he was an old person. He's -- so it doesn't matter anymore. But he's selling it to people who might be a little bit younger, so --

And I can do questions at this point, but you want to go ahead and go for the extras? Go for the extra photos.

Matt sent us -- he had better photos than I did. I'm so jealous. He had much better photos than I did.

Okay. This one, he has a shelf of mineral specimens. I assume mostly radioactive material. Radioactive ones.

And then next slide, please. That's another

view of it.

And this is his, this is his pride and joy. This is his periodic table. The ones -- so he obviously has not filled in everything from down in the -- let's see. Down in the actinides he's still working on that. But he's, you see he's got specimens of all the other elements.

I think that clock was wrong. Wrong, by the way. I don't think it was quite that late in the afternoon when we visited.

Next slide.

JAMES FUTCH: Why does he have a clock in there?

ALLEN MOODY: It's apparently made that way. I don't know if this is something he bought commercially made or if this is something he made himself. I don't know.

NICHOLAS PLAXTON: They used to use like a paint on there.

CHANTEL CORBETT: Radium.

NICHOLAS PLAXTON: Radium on there.

ALLEN MOODY: Well, no, because it has a slot for Radium down here. It has a slot for radium up here. That's where radium should be. And I think he's got something in that slot.

Next slide?

He's got -- this is just a work bench in there. I don't know exactly what else he has in there.

Next slide.

Another view of his glove box.

JAMES FUTCH: Is that an acetylene tank in there?

ALLEN MOODY: Huh?

JAMES FUTCH: What's the gas tank down there?

ALLEN MOODY: He's got, well, he says he has, like I said, I know he's played with hydrogen because I know he said he was using hydrogen. Hopefully not in this. But he -- if he's got a gas supply to this, I have no idea. But, you know, unless he was using some sort of an inert gas in here for some reason, which I would hope if he was doing that, he had better ventilation than what we saw.

CYNTHIA BECKER: He had the stove.

ALLEN MOODY: Kitchen stove, laboratory, prep area. He seems to have a little, either a hot plate or stirrer or -- actually, I think it's a hot plate stirrer over here. Of course, he's got his balance over here and his microscope.

JAMES FUTCH: Is this his actual kitchen?

ALLEN MOODY: Huh?

JAMES FUTCH: He's fixing food in this kitchen, too?

ALLEN MOODY: I hope not.

REBECCA McFADDEN: This is the little apartment up the hill.

ALLEN MOODY: It's a garage -- it's basically like a garage apartment.

REBECCA McFADDEN: The mother-in-law suite.

ALLEN MOODY: There's a garage area, there's like a carport area in the middle of it and then there are rooms on the side. And the rooms on the side is where he keeps his library. And he has a library of, like I said, of mainly older radiochemistry texts.

Next slide.

This is a, this is his chemical storage area. He's got his all his chemicals up here or whatever he was using. And I assume he's got basic acids and a few other basics up there. Like he said, he does not have the resins or the extractants to do or chelating agents that you would need to really do separation, proper chemical separations.

Next slide.

I think this is where we started bringing it

back. When we brought these materials back, for safety consideration, it was like, we double bagged them in plastic bags when we were bringing it back from the car. And I think we kept the windows down, too.

Well, there was a lot, there was a lot of Radon in this stuff, okay? There's a lot of radon in this stuff.

RANDY SCHENKMAN, CHAIRPERSON: Put it in a metal box.

ALLEN MOODY: It looks like he's got a centrifuge back there. He does seem to have one.

JAMES FUTCH: Is that for the uranium market?

ALLEN MOODY: Huh?

JAMES FUTCH: Is that for the uranium market?

ALLEN MOODY: I don't know. No, I don't think he's doing -- I do not think he's quite up to, to doing, to doing enrichment with these. But that was the thing about it. All his material, except for the americium, was natural material. So because of the regs, the regs are so structured, that he can have, you know, John Lacey (ph) was saying kilogram quantities if he wanted to, of natural material. And so he was -- had quite a bit of it.

There was a lot of stuff we really couldn't put

a number on. He had bottles of yellowish liquid, which was yellowish. It's probably uranium, but because it's in liquid form, you can't -- because it's in solution, it was very, very hard to get a number. We couldn't really get a number on it. Because uranium, natural uranium's gamma energies are fairly low and so they're going to be strongly absorbed by water. So it's in an aqueous solution. It's going to be very, very hard for us, especially to tell how much is there. Especially considering the fact that, you know, you don't have -- you do not really have a gamma geometry for a jar that's about this big (indicating).

Next slide.

This is a rack of his electronic equipment. He's got -- I don't know how much of this stuff actually works, but he has, you know, quite a bit of it.

Next slide.

I'm not quite sure, this is -- somebody asked me about what this was. I'm not sure. Whether that's some kind of an oven or what it is. Does anybody recognize this thing?

ADAM WEAVER: It looks like an old furnace.

CHANTEL CORBETT: You were saying he was doing

something under heat, right, that couldn't have oxygen.

ALLEN MOODY: What he was doing, what he was doing --

ADAM WEAVER: Passing gas through it.

ALLEN MOODY: What he was doing was, he had uranium metal and he was basically reacting it with hydrogen. Like I say, you have to have -- all the air has to be gone or else it's going to blow up on you the minute you apply heat to it. But what he was describing was, he was saying, oh, I varied the temperature and I'd see the hydrogen and see the uranium changing as it turned into hydride and then I changed the temperature and it would go back to uranium metal and he was very enthusiastic about that, about the chemistry. Not safety but -- is that the last one?

JAMES FUTCH: Nope.

ALLEN MOODY: That's another view of his electronics.

JAMES FUTCH: Is this used stuff?

ALLEN MOODY: Yeah. A lot of it is used stuff. I assume -- he says he can work on this stuff and says he can make the, make the equipment work. But, you know, he was just buying what he ever he could

get off EBay, somebody's surplus, if somebody was going to throw it away. I guess he was scavenging it for electronic components.

This guy would, you know, be kind of frightening if he seriously got into the terrorists, got into terrorism or something like that. He knows, he knows his stuff to a large degree. There are issues, like I said, in chemistry that he does not seem to have a lot -- a great deal of knowledge of. But he's, you know, he's -- the electronics he says he understands. Apparently, he knows how to work a Germanium detector. He knows basic -- the stuff he can do with acids and bases, he knows that, that end of it.

STRATIS LAGOUTARIS: What did he do for a living that he retired and suddenly took up this hobby? What was he a retired schoolteacher or something?

ALLEN MOODY: Do you want to know what he said he was?

STRATIS LAGOUTARIS: Yeah.

ALLEN MOODY: He said he was a neuroscientist in his career.

MATTHEW WALSER: What did he do to get on the radar screen?

ALLEN MOODY: How he got on the radar screen, remember I was talking about this americium and beryllium sources? He had posted a YouTube about that. Apparently, he was -- you know, he says he didn't sell any of these things, but it's kind of hard to understand why he would make a YouTube about them if that had not been his intention. Apparently -- but he posted a YouTube about this and then the NRC got wind of it and then they contacted us.

CHANTEL CORBETT: You said the background was only three microbar?

ALLEN MOODY: Well, the background outside was three microbars. The background where we can get a clean background was about three microbars. About 24 inside.

CHANTEL CORBETT: Yeah, I was going to say because the landfills locally in Central Florida, their monitors are set up for, like, 24 microbars. So most of that would still go pass through --

ADAM WEAVER: Pretty low.

ALLEN MOODY: Remember, also, like I said, that was after, about three, four months after we had taken all this stuff out of there before we put it back that it was reading that.

CHANTEL CORBETT: Right.

REBECCA McFADDEN: So there was really nothing that he could be charged in doing wrong. You didn't find any over the amounts which he was able to have. So he -- nothing could be shut down. He's still there doing his thing?

ALLEN MOODY: As far as we know. I have no idea. No, our part in this ended when we took him back his stuff in November.

REBECCA McFADDEN: Right.

ALLEN MOODY: We returned his materials in November and if he wants to cheerily go on selling his stuff on EBay, as far as we know, it's legal as long as it stays away from the americium. It's not really recommended practice, I would think. But, you know, we've got into this discussion here so many times that things are probably not a good idea but are not illegal.

WILLIAM ATHERTON: Just why is the americium special?

ALLEN MOODY: Because there's a law that says you can't repurpose the americium 241 in smoke detectors.

WILLIAM ATHERTON: Was there a logic behind that?

ALLEN MOODY: I don't know why. Anybody know why the reg. was written that way.

ADAM WEAVER: It's transuranic material.

ALLEN MOODY: Transuranic material, yeah.

JAMES FUTCH: So it's five microcuries per device. Well, that's home units.

ALLEN MOODY: Home units. These are industrial ones and they are 80.

JAMES FUTCH: You guys all know this anyway. How many smoke detectors do you have in your house? Five times, whatever that is in microcuries. You have 10 or 15 microcuries in your house. Deposit it on a piece of metal.

ADAM WEAVER: Industrial units have more. They would be more sensitive.

ALLEN MOODY: Is that the last one?

JAMES FUTCH: But you have to leave it there. You can't scrape it off and put it in a jar.

ADAM WEAVER: He just cut them off.

ALLEN MOODY: You can't do what he did was trying to put it on metal strips or you know, whatever.

ADAM WEAVER: Well, adding beryllium makes it a potential neutron source.

ALLEN MOODY: Well, it does, but -- I don't

have a picture of it here. I only have a picture on my phone, of his so called americium beryllium sources. I couldn't get neutrons, I couldn't read neutrons off it with the Ortec. The Ortec actually has a neutron meter on it. But that doesn't mean it wasn't emitting neutrons. It might just emit at a lower level than we could see with that detector.

But, again, the main hazard from those, that stuff is basically the fact that instead of using foil, and I don't know why on earth he didn't use foil. He was using beryllium power and beryllium powder is acutely toxic. An inhalation hazard. You do not -- you do not want to disassemble one of these things. They're dangerous just from inhaling the beryllium.

Is that it? Okay. Any other questions?

JAMES FUTCH: That's it. That's the beginning.

ALLEN MOODY: That's the beginning. Any other questions?

RANDY SCHENKMAN, CHAIRPERSON: So what was the difference between the yellow to the red orange?

ALLEN MOODY: I don't know. It's a peculiarity of his chemistry.

RANDY SCHENKMAN, CHAIRPERSON: But they didn't -- it didn't register differently?

ALLEN MOODY: No, because it's still, it's, it's a purity issue. But it's the same thing. He had some, he had one compound that was, that was green, brown and black.

ADAM WEAVER: Those could be different forms of uranium.

ALLEN MOODY: Because remember, he has no quality control. So it could be that or it could be just impurities, various chemical impurities in the stuff that's making it this color versus that color.

Uranyl, by itself, the uranyl cation is yellow. Most compounds, that's why most uranium compounds are yellow. But, you know, if you have various kind of chemical impurities, they could be various other colors.

ADAM WEAVER: They used to make plates called Fiestaware that were painted with different uranium chemicals and they were green, orange, yellow.

JAMES FUTCH: Some blue.

ADAM WEAVER: Blue, it could be all kinds of different -- actually, the blue may have contained thorium. You can look it up. It's not the new Fiestaware because we have some of that in my house. My wife likes that. The old stuff. You can buy it. It's probably still on EBay.

ALLEN MOODY: He has one. He has a Fiestaware plate. He has a Fiestaware plate. He has, he has samples that are supposedly trinitite. You know, you can't even -- actually, if you go to, and I've been to the, I've been to the Trinity's test site. You can't even get that anymore because they've taken it all away because they didn't want people walking off with radioactive material. So I don't know where -- but he's, he's done a lot of shopping online and I guess you really can get anything on the internet these days.

JAMES FUTCH: Did he -- when NRC informed you guys, did anybody contact the sheriff's office in the county which he resides and make them aware of his existence? Not that he's done anything illegal.

ALLEN MOODY: Actually, we went down there. We had a deputy, I believe the deputy went with our survey person down there because we weren't quite sure of his state of mind. So, you know, a deputy, I believe, went with Kelly when we first went down there and got the material. And then we pretty much decided he was -- I don't know if you call him a harmless crank, it's definitely crank, but it's not really a hazard in terms of violence. We said, okay, fine.

So I went back with, with Matt Sinison in November to return the material and to talk with him a little bit and see, you know -- get some, get a few answers, basically.

NICHOLAS PLAXTON: I was going to say this story reminds me, I don't know if you believe it, maybe you read that story about the radioactive boyscout. Do you guys remember that?

This is like, sounds just like that where the kid, for his Eagle Scout, made a reactor in his backyard. It was actually in my neighborhood when I was in Michigan. I had to go back and look and see when I went to school. It was right outside the school when I went to elementary school.

ADAM WEAVER: They didn't give him his merit badge. Not that they ever gave him one.

NICHOLAS PLAXTON: But the Navy eventually hired him to be on a nuclear sub.

ALLEN MOODY: Well, I mean, this guy, it would be nice if you could find some constructive way for him to use this enthusiasm. But he's retired. What are you going to do with him?

JAMES FUTCH: Allen, do you want to hire him? He can come work in your lab.

ALLEN MOODY: Yeah. But I could make his

business much more efficient. He could actually, he could actually be selling pure stuff instead of making --

JAMES FUTCH: Maybe you shouldn't hire him.

CHANTEL CORBETT: We can make him more profitable. Come on in.

NICHOLAS PLAXTON: Yeah, the radioactive boyscout died a few years ago from the radiation poisoning.

ALLEN MOODY: That's a thing, too. If he were actually doing purification, he would be generating a lot of radioactive waste because that does --

JAMES FUTCH: Did he become -- did he, after your talk about safety, did he become more aware of the, the importance of controlling airborne alpha emitters and radium oxide plain black powder.

ALLEN MOODY: I talked with him about all that. He is seeing this thing from the point of view of, well, it's not, it doesn't matter for me because he's, because he's, you know, he's at that age. But, you know, I did tell him that some of this stuff is hazardous. The dispersal of the stuff especially. Because we -- that is the worst thing. The worst thing is to have a disbursable alpha. Because, you know, you get it in, in your lungs and

it's, you know, it's a very high cancer risk for anything, any powder and that -- while it's more true of Plutonium or higher activity, specific activity nuclides, it's still true of, you know, of things like, well, certainly of americium. But also to some degree, I guess uranium, too.

RANDY SCHENKMAN, CHAIRPERSON: Does anybody have any more questions or should we move along a little bit?

Very interesting. Thank you.

(Applause)

RANDY SCHENKMAN, CHAIRPERSON: Okay. James, you're up.

JAMES FUTCH: Am I up? Okay. I'll sit over here.

So let's start with 64E-4 because we've talked about that one before.

Adam, I apologize if I have my back to you.

ADAM WEAVER: That's okay.

JAMES FUTCH: But -- so you may recall from a previous discussion that I think largely Adam and I had about laser, laser regulations.

ADAM WEAVER: Laser.

JAMES FUTCH: And so we had in, in March of 2017, we did our last rule amendments and changes

for the state laser regulations. So the state laser rules are a combination of the device-specific requirements that FDA theoretically requires of all devices manufactured or imported into the U.S. And the user-specific requirements that stem from a voluntary laser safety standard called ANSI Z136. And the Florida regulation that we've had has been around since 1984; we'd periodically updated it.

So we had updated it in March of last year and brought it up to speed with the current version of the ANSI laser safety standard, on the user side, which is ANSI 2014.

Along about that time, there were also some, some changes in philosophy, as often happens in regulatory agencies, and certain viewpoints kind of went out and we were encouraged to move a lot of the regulations into a, into a document incorporated by reference. So we used to have 13 laser rules. Separate rules. 64A-3 and 1 through 13 and 14. And we took all of the regulations that were in 2 through 13 and put them into a document incorporated by reference, which means it's a Word document, has all the same exact language in it. It's just in a document which now resides in a book inside the first regulation. Point 001. Nothing changes.

Obviously, we updated the ANSI reference. Nothing changes.

Well, the way that finally percolated into existence is we ended up on the Department of State's landing page, if you will, for this particular rule. And the only rule that still had substance to it was the top one, 64E-4.001, and it had no subject listings to it at all. And all the rest of the rules, all said repealed, repealed, repealed, repealed. So if you don't know anything about laser safety in Florida, as Adam pointed out, not that you don't. You do, obviously. I'm saying somebody who doesn't, like a couple attorneys who contacted us saying, hey, did you repeal all your laser regulations? No, we haven't done that. But if you look at that website which is the place where everybody who's looking for regulations looks, who's a lawyer, you would miss the first rule, right, and you would see the balance of the rest of the page says repealed on it.

This took a little bit of fixing so that we were not erroneously leaving the impression with the entire State of Florida laser users that we no longer had laser regulations.

So we've finally, through Brenda's efforts and

my own and a very cooperative person at the Department of State, ended up -- of course, the computer decided it's not working. This would be a lot more effective if it would actually open.

While the computer is catching up, basically we got the Department of State to --

CHANTEL CORBETT: It's behind it.

JAMES FUTCH: There it is. Thank you.

So now, this is what it looks like.

So this is the one rule that is still in existence and you can see they allowed us to add back all the subjects that still exist and are still regulated by the State of Florida. So all these things you see, safe operations, postings, surveys, instrumentation, laser light shows, if you go to your light show concert, and all the places down below like this one, definitions where it used to say repealed, it actually refers you back up to this regulation for all the current requirements. So you no longer are hopefully left with the impression that the thing has actually been repealed. Really, what's happened, it's all moved to the top regulation. If you go and look at the top regulation, you will now actually find everything. It's where it's supposed to be.

So what I just described is kind of one of those very laborious but necessary things to make sure that people still are aware of laser regs. And that's all I have to say about Dash 4. Any questions?

ADAM WEAVER: Florida still has laser regulations?

JAMES FUTCH: Yes, we still do.

ADAM WEAVER: Some states don't.

JAMES FUTCH: I know.

ADAM WEAVER: There are some states that don't regulate lasers right now.

JAMES FUTCH: We still do.

ADAM WEAVER: Florida still has and is one of the first states that to have it.

JAMES FUTCH: Yeah, it's us, New York, Texas, Massachusetts, Arizona.

ADAM WEAVER: Yeah.

JAMES FUTCH: Probably one or two others I can't remember anymore.

All right. So that's Dash 4. The other one popped up.

All right. So on to Dash 3. So you've actually got the language in here for a couple of these I think, Brenda.

NICHOLAS PLAXTON: We do.

JAMES FUTCH: So in your packet of materials, after Allen's presentation, we have some proposed, proposed rules and -- all right.

So this first one is 64E-3.003, qualifications for exam. So we began this process a number of months ago. And this section of the regulation that you're looking at, I won't go through all of this, but if you look at the bottom paragraph, this is the section that governs the standards for examination for what we call the basic x-ray machine operator on limited scope and radiography. You heard us refer to this earlier in the context of Kathy asking how someone can find out if we're going to accept their criminal history for licensure as a radiographer.

So this textbook that I'm holding, this is a textbook available from one of the publishers that's been around for a number of years. It is -- it's written to follow one of the national registry's examinations for what they call limited scope radiography. This particular one, this is the 5th edition that we're holding here.

So this section of the regulation has been around for a number of years. And it basically states that the exam that we're using is going to

follow along these subject areas. Because this actually functions as the educational program for somebody who wants to apply for a basic x-ray machine operator license. And it, thankfully for us, we used to have our own textbook that we produced from 1983 until 2000 something. 2002, 2000, somewhere in that vicinity. And, of course, it's kind of hard to write your own textbook, especially when it has 3, 400 pages and as technology and imaging changes, to try to keep up with it.

So capitalism and entrepreneurship responded and somebody said, wow, look at all these folks who are taking these exams all across the country. Let's write a book so they can buy it and study for those tests.

So when we first put this regulation together, this book I think was --

KATHY DROTAR: 1st edition.

RANDY SCHENKMAN, CHAIRPERSON: 4th.

JAMES FUTCH: Well, the 1st edition was completely different authors. But then this company took over and these new authors --

KATHY DROTAR: Bruce Long.

JAMES FUTCH: -- from the 2nd edition forward.

Yeah, Bruce Long. So we updated the standards or are in the process of updating the standards. The notice of rule development was published in --

BRENDA ANDREWS: January of '18.

JAMES FUTCH: Strangely enough, just yesterday, this rule language was published for comment.

BRENDA ANDREWS: Really? Okay.

JAMES FUTCH: I checked this morning.

BRENDA ANDREWS: Okay. Finally.

JAMES FUTCH: Long time promulgating rules. And so, basically, once this goes through, we will, we will again be up to snuff with the appropriate national practice on this particular examination.

REBECCA McFADDEN: James, do you mind if I ask a question? You're referring to the basic operator, correct?

JAMES FUTCH: Yes.

REBECCA McFADDEN: If there is a student who's currently enrolled in a program, and they are, you know, somewhat through that program, it's still required that they purchase the book?

JAMES FUTCH: No.

REBECCA McFADDEN: Or is that part of this --

JAMES FUTCH: Yeah, the language -- if you actually read the language, it says -- where is it

at?

REBECCA McFADDEN: Oh, it's not required to provide verification from graduation --

JAMES FUTCH: Yeah, they don't.

REBECCA McFADDEN: -- the course of study for such an applicant is to review the book.

JAMES FUTCH: Right. So the way the basic is handled, is they, they can, of course, go to a national program. There are a few left. There's not very many. There are a fair number that are medical assisting programs that have a basic x-ray component to them. And then I think there's -- Lynne, help me remember, two or three actual full basic programs around the state?

LYNNE ANDRESEN: A couple.

JAMES FUTCH: Everybody else is going to on the application, self-certify they have reviewed this textbook.

REBECCA McFADDEN: Okay. So if they don't -- let's say they're in a two-year program. It's their first year, they want to go ahead and get their basic.

JAMES FUTCH: You'll talking about full radiology.

REBECCA McFADDEN: Like a radiology -- they are

part of a radiology program. They want to get their basic after the first year. Do they need to purchase the book and have it reviewed in order to apply for this exam?

ADAM WEAVER: Doesn't it say or?

JAMES FUTCH: Yes.

ADAM WEAVER: Or equivalent.

JAMES FUTCH: Yeah. In the language in the text here at the bottom of the page, which is 64-3.003, see how we changed the number? It says published by any substantial similar course which provides instruction on each subject listed in the ARRT limited scope study guide. So they can use the 3rd edition, they can use the 2nd edition if they want to.

REBECCA McFADDEN: Okay.

JAMES FUTCH: What we're doing --

ADAM WEAVER: Or the text if they can find one.

JAMES FUTCH: Yeah.

REBECCA McFADDEN: Yeah, one of our clinical instructors asked me to just confirm and I didn't want to translate.

JAMES FUTCH: No, they don't have to run out and buy this textbook.

REBECCA McFADDEN: Okay.

RANDY SCHENKMAN, CHAIRPERSON: This says the 4th edition and you're saying you have the 5th edition.

JAMES FUTCH: Remember when I said that there's a long process involved? So when we started this, the 4th edition.

RANDY SCHENKMAN, CHAIRPERSON: The 4th edition on.

JAMES FUTCH: Yeah, at some point in the future, maybe after I'm retired, Brenda, you can start the --

BRENDA ANDREWS: I'll be gone.

JAMES FUTCH: I'm just kidding.

CLARK ELDREDGE: The rule's out for comment now. Any one of you can write in. Don't you want to update it to the 5th, and then you can do it right then.

JAMES FUTCH: Sure. Six months from now we'll have that one finished.

All right. So that's standards for limited scope practice.

And then we will come to -- Chantel's over there waiting to jump in on this one.

CHANTEL CORBETT: No.

JAMES FUTCH: All right. So if you turn over

to what's page three up at the top, it will say full text of the proposed rule 64E-3.002 and then 3.004.

So let me describe this one. So what you're seeing here, and it's very hard to kind of follow along in, in this because you don't see what the previous version looked like, but let me back up and explain.

So these two sections of the rule, one of these is what we call the specialty technologists section of the rule. That's .0034 and .002 is definitions. And one of the definitions in, in the definition section is the practice of radiologic technology. So we're doing two different things here. Related, but they're in two different parts of the regulations.

So several years back, we had a change in our authorizing Statute 468, which allowed us to issue new types of licenses based upon national registries that had other kinds of licenses for imaging or therapy that we did not have. So from 1978 until 2008, I think it was, we had limited scope, we had general radiography, we had nuclear medicine and we had radiation therapy. We didn't have things like CT or mammography or PET, positron emission or any of these other kinds of things.

So when that law changed, it gave us the ability through rule, to enact new kinds of certifications in Florida which matched what the national registries were putting out. At that point in time, we went through rule promulgation and we set up CT and mammography and PET, positron emission. And this section .0034, was what was set up in rule at that point in time.

So in the rule, you have to specify certain things. You have to specify who's going to qualify, which means you have to, you have to recognize the national registry credential. You have to specify what they're going to call themselves, what their titles are going to be, what their initials are going to be on the cards that Dr. Spivey and Gail's group issues. You have to specify what their practice standards are going to be. All those things were done in .0034 and everybody's happy.

We're not talking large numbers. I don't know if you remember the slide from before, but there's, you know, 20,000 plus general radiographers; 2,000 plus nuclear med techs and the number of CT and mammo and PET, all these together number in the couple hundreds. Maybe 500 I think. Something like that. Anybody remember the number? I've forgotten.

Not over a thousand. But, but still very, very important for people who are practicing in those areas and wish they have their licenses at the national level, acknowledged and allowed to practice under those licenses in Florida.

And this affects some professions differently. So, for example, people who are licensed as nuclear medicine techs, they were mostly prohibited from doing any kind of CT for a long time, even though the technologies merged together as PET/CT that we've talked about before, until this law passed. And at this point, they were able to go to the national registry, ARRT, and obtain a CT license, and then come to Florida and provide it to us and then we would issue a CT license. Now they can do full CT on a PET/CT machine or whatever combination of nuclear medicine or CT, whatever they want to do. So everything was fine and everybody was happy.

And then the other national registry, NMTCB, which is a fine registry, came along -- Chantel is our go-between for NMTCB -- and they decided to create their own CT registry. And guess what? We didn't recognize that in Florida law. So we're like, no problem. We'll go back to the statute, and okay. They've got this and this. Oh, wait a

minute. Their practice standard is not one that is for CT by itself. It's CT, it's part of nuclear medicine, and we went to the lawyers and it's like, you've got to have one that covers that.

So it took a while, through the efforts of the Society of Nuclear Medicine and NMTCB -- maybe Chantel had a part in it, I don't know. We had a person come down and talk to us, you remember this from several years ago.

The key thing that we've been waiting on for the past couple years is for the ARRT and the NMTCB -- excuse me, ASRT and the Society of Nuclear Medicine to come together and modify the existing scope of practice that ASRT was using, which we had already recognized years, some years ago, and adapt it to fit both pathways, which they did as of last June.

And we have -- so where we're at with the last, .0034 is, we've recalibrated .0034. It's made it through rule development. Brenda, help me. Where are we? Made it through rule development last month or the month before.

BRENDA ANDREWS: March.

JAMES FUTCH: Okay.

BRENDA ANDREWS: March 24th.

JAMES FUTCH: And the language is out. NMTCB has seen this language. ASRT has seen this language. You are seeing this language. It's extremely -- there's nothing controversial. It's basically move some stuff around; reorganize it so that it makes sense that you can now issue based upon this other national registry.

So we're down to, it's out of our hands. It's way out of our hands. It's somewhere above us in the rule promulgation process and should be coming out as a notice of rule promulgation posted on the Department of State's website at some point. And hopefully nobody has substantive changes that need to be made, which would delay it further. And once we get that, we can, we can begin accepting -- don't say anything -- beginning accepting CT from this other national registry.

At the same time -- and I'll come back to the point about this accepting and issuing CT -- the first half of this is the change in the definition of, in the practice of radiologic technology. So right now, we recognize in the regs, practice standards from ASRT for CT, for mammo, practice standards from ASRT, as soon as this is finished, from, from the other side of the CT world, practice

standards from Society of Nuclear Medicine for PET, and that's great. That's all the specialty technologists. But the general radiographers, mostly, and to a certain extent, the radiation therapists and to a much lesser extent, the nuclear medicine technologists, all they've had for a practice standard in Florida for a long time is this definition, this unmodified version of the definition of the practice of radiologic technology, which basically says the practice of radiologic technology means the performance of activities requiring special knowledge and skills, including positioning techniques, safe operation of radiation equipment and radiation protection.

So not too specific. And yet, there are actual practice standards that have been in existence at the national level for decades for radiography, for full radiography, for nuclear medicine and for radiation therapy.

So the second half of what this rule promulgation does is adopts those, also, for use in Florida by the rest of the technologists.

And that's it. Any questions?

RANDY SCHENKMAN, CHAIRPERSON: Anybody have comments? Anything?

KATHY DROTAR: I have a question.

JAMES FUTCH: Go ahead.

KATHY DROTAR: So now that NMTCB has recognized it as CT, okay. Now, how does that nuclear med person train for that, because they weren't able to do CT. So can they do that now or do they have to be in a program?

JAMES FUTCH: So this hasn't changed. The way the laws are written in Florida, that person should be doing it underneath the auspices of a program. However, it's also possible to do, I forget the percentage -- we've gone through this, I don't know how many times -- there's a certain percentage of the required clinical competencies that can be accomplished.

Chantel, why don't you tell me what I should be telling them.

CHANTEL CORBETT: Sorry. The ARRT has the specific list of, of clinical competencies. The NMTCB is based on experience hours.

KATHY DROTAR: Okay.

CHANTEL CORBETT: So they're two different things. Remember when we discussed all that in multiple sessions. That's the biggest difference. So that nuclear medicine techs, especially in

Florida, can be qualified for this without going back to school. Because when you're a full-time tech and living an adult life, it's really hard to go back to a two-year school just for that. So -- and the ARRT has always said, technically, we want you to do one hundred percent of the scan. So, technically, you would have to push the button.

Now, for me, I've always -- the argument has always been from other clients, all the technologists saying, look, if I've done everything else, you know, contrast is already in the scope of practice for nuclear medicine techs, so if I do everything else except push the start button, can I count that? And they say no. So we've never been able to do that without going back through a school program. But the NMTCB allows us to do the number of hours -- and I believe it's 400 hours -- in a clinical environment. So that does not require actual schooling.

KATHY DROTAR: So you're not actually scanning.

CHANTEL CORBETT: You could be scanning, yes, as part of a, like a PET/CT.

JAMES FUTCH: That's what I was trying to say.

CHANTEL CORBETT: Yeah, I mean it could be part of that set protocol and you could still be within

your rights to do that.

NICHOLAS PLAXTON: So it's like on-the-job training then?

CHANTEL CORBETT: Well, it's not -- yes and no. I mean, you don't have to be part of a school program, but you still have to be in that environment the number of hours. So if you're already a PET technologist, and you're doing PET/CT all day, there are certain parameters where it's allowed as part of the set protocol, where you're not doing standalone CT by itself, because that's not allowed.

NICHOLAS PLAXTON: But once you reach that number of hours --

CHANTEL CORBETT: Then you have to go take the exam.

NICHOLAS PLAXTON: Take the exam.

CHANTEL CORBETT: Yeah. And it includes, you have to have the educational portion as well and then the experience portion. Then you have to go take the exam, get the certification and turn that into the state once it's approved.

KATHY DROTAR: Okay. So under that auspice, and you're just doing -- that enables you to do PET/CT?

CHANTEL CORBETT: Once you get your license, you'll be able to do all CT.

NICHOLAS PLAXTON: You can do full CT without PET, if you get your license.

CHANTEL CORBETT: Correct.

JAMES FUTCH: Not even a PET/CT machine.

NICHOLAS PLAXTON: You can work in a radiology medicine department and in nuclear medicine department.

JAMES FUTCH: I'm not sure how many will do that, but you could.

CHANTEL CORBETT: Very few will do that because it will be a significant pay cut, honestly.

KATHY DROTAR: No. I was just worried on -- thinking on the other end. If you're, you know, just observing something and not actually doing.

CHANTEL CORBETT: None of your new x-ray techs coming out of school have done any CT for the most part.

KATHY DROTAR: That's not true.

CHANTEL CORBETT: Most of the ones in the field do not do CT as a student. The most recent ones, yes, but historically, no. They came out with no cross-sectional anatomy and no CT experience and they were trained completely on the job.

KATHY DROTAR: When I was in x-ray school, there was no CT. So, yeah.

CHANTEL CORBETT: Nuclears have had cross-sectional anatomy forever, since spec existed, so education wise, you know, I think that they've always been further ahead than that.

KATHY DROTAR: I was just -- I wasn't worried about the education. I was just wondering about the ability to actually perform the scans and how much, you know, and advising our nuclear medicine people what would their students be able to do. I think that's certainly appropriate in their curriculum now.

CHANTEL CORBETT: Yeah, most people in nuclear medicine programs have CT programs.

NICHOLAS PLAXTON: The question I had now, what we were talking about, people that are already working, but people that are coming through the nuclear technologist schools now, will get this as they come out, right? They don't have to do anything further.

CHANTEL CORBETT: Correct. Most of them already have the --

NICHOLAS PLAXTON: They will take the test when they finish their program.

CHANTEL CORBETT: Yeah. So I know HTC, I know they have theirs completely incorporated into their program where they will actually have -- they are able to sit for the ARRT and the NMTCB both coming out of school.

JAMES FUTCH: Yeah. I would hope that the programs for new folks coming out are incorporating CT as much as possible.

CHANTEL CORBETT: Right. And like I said, the nuke med programs have switched now so they are already sitting for ARRT coming out so they will have the actual exams and the hours. And like I said, some of the bigger hospital groups are very much pushing their techs to get the CT license in order to be able to run a PET/CT.

KATHY DROTAR: Right.

CHANTEL CORBETT: And so that's the little group, where you have these people who are -- have been in jobs for years and years, and basically are being told, you either go get this or we're going to just hire somebody else and you won't have a job. You know, we'll have to switch you over to do something else.

NICHOLAS PLAXTON: They are only doing it by choice. Because in order to run a PET/CT, you

wouldn't need it. But technically, many --

CHANTEL CORBETT: Basically, what they are doing is they are trying to prevent having to pay multiple people and all that kind of thing, too.

I don't know, what are you guys doing at Florida Hospital? Do you know if they are pushing it?

MARK SEDDON: We have the dual -- a lot of times we have the ASRT, the RTs running the PET/CT's. That's generally the most common.

CHANTEL CORBETT: Yeah, so they can a nuclear med tech and an x-ray tech.

NICHOLAS PLAXTON: So you have two.

CHANTEL CORBETT: Yeah.

NICHOLAS PLAXTON: We've just nuclear med techs run ours. They know how to do it.

CHANTEL CORBETT: And Beth's place is, too. You've got the bigger groups that do just PET/CT, which is really just CT for continuation correction, then you've got places who are literally doing diagnostic CT's in between every PET as a separate patient. So that's the two different main centers where you're going to have it.

RANDY SCHENKMAN, CHAIRPERSON: Can I interrupt? We only -- we have less than half an hour and I know

we have another presentation. So can we -- did anybody have any more questions or can we end this one and bring --

JAMES FUTCH: One thing that I was curious, you guys have the language in front of you. You're familiar, in your areas, with the practice standards that are out there. The national standards. Do you think we're on the right track? We're moving? Okay.

RANDY SCHENKMAN, CHAIRPERSON: Yeah.

KATHY DROTAR: Yes.

RANDY SCHENKMAN, CHAIRPERSON: Okay.

JAMES FUTCH: Where we going?

RANDY SCHENKMAN, CHAIRPERSON: Clark?

CLARK ELDREDGE: Back to mine. We'll probably pick one or two things out and then we'll have to table the rest, I guess, to next time or we'll be moving ahead to some of these things without your comments.

JAMES FUTCH: Do you have the clicker?

CLARK ELDREDGE: No, he does.

JAMES FUTCH: I don't remember where you were.

CLARK ELDREDGE: Just the first one. Healing arts. Do you want to start it?

JAMES FUTCH: Sorry.

CLARK ELDREDGE: Harm to patient. We have in medical event reports, that a medical event, any medical use that results in unintended permanent functional damage, all right, is one thing that is considered a medical event to report. And in these reports, we also after, you know, from the other, the wrong patient, the wrong one, generally, there's some statement from the team, there was no harm to the patient. We just did, you know, a wrong isocenter, we just did this, but there was no harm caused. And I'm assuming that their whole basis for saying there's no harm is they said there's no permanent functional damage to the person. Yet with radiation safety, things we know that there are temporary functional impairments, there's, you know, increased to cancer risk as well from high doses of radiation.

So I was looking at adding a harm to patient and potentially replacing the -- this part with a medical use that results in this, instead of any medical use that results in harm to the patient and adding a definition of harm to the patient. Which includes, first, the permanent functional damage for any -- that was not intended -- is determined by a physician not intended as a expected outcome of the

procedure or treatment.

Temporary functional damage. Again, as determined by a patient, physician that was not an intended or expected outcome. And I was wondering if, there I was thinking of instead of, as we know that therapy is done for curative as well as palliative purposes -- leaving the temporary functional to a palliative or diagnostic procedure. And then any time that there's a dose that's messed up that increases the cancer risk by 50 percent over what was the anticipated from the dose provided from that procedure or some other appropriate percentage. That that would put a limit on, from the prescribed amount of the radiation necessary for the medical procedures.

So limit, you'd have the doctors saying this is how much dose we need. If the alignment of the -- if the procedure was done in such a way that either wrong part was eradiated, other dose limits that if you significantly increase the cancer risk.

Now, of course, within that you could also say that the cancer risk also has a time age limit in it. So if you actually overdose somebody who's not expect to live for three years, you don't have to worry about that part. But if it's a younger person

where you're trying to cure them of some disease or diagnose them, you know, that would be a consideration of that being harm to the patient that you've done something that's -- because, you know, you'd certainly allow in that test effect calculation, expected life of the patient versus how long it would take effect for the radiation to show up as a cancer risk.

MARK SEDDON: The third one is not going to fly.

CLARK ELDREDGE: Not going to fly?

MARK SEDDON: There's no way to quantify that realistically. So I mean, you can -- the first two you could put, you know, permanent functional damage. But as far as somehow saying if that someone's off by ten centimeters within the liver that you can put down what is the stochastic effect if it's 50 percent higher. There's no agreed-to value to it. You can't really look at it and say, well, looking at, you know, cancer risks from a certain amount of exposure to tissue, because there's --

RANDY SCHENKMAN, CHAIRPERSON: There's no table to go to.

MARK SEDDON: Yeah. There's no table.

CHANTEL CORBETT: There's no standard.

MARK SEDDON: There's no standard. That's really kind of a gray kind decision of -- it's still being researched as type of the secondary effect you're going to have from treatment. That's ongoing. I don't know if you can really put that in a regulation or a definition like that. It would be difficult. It would be hard for any physicist to make that determination.

For, like, if you have a, like I say, if you miss osicenter on a treatment --

CLARK ELDREDGE: Right.

MARK SEDDON: -- how would you --

CLARK ELDREDGE: Well, you've got your -- if you miss the osicenter, you know what your calculated volumetric dose to the rest of the tissues are and how much you overcharged those tissues by.

MARK SEDDON: Yeah, so the current numbers have actual values. You can look if it's 50 percent above the expected dose from planned to the surrounding tissue. But as far as if that is some type of an increased risk, that's going to be the part that's going to be difficult.

ADAM WEAVER: It's very hard to quantify that

and even qualify that.

MARK SEDDON: I think if you stay away from that third one, even more the other numbers, you have dose exceeds expected by 50 percent, whatever the number is, you know, more than half.

CLARK ELDREDGE: Well, that's actually, that part of the language for the isocenter missed that increased the dose to the non -- increased the dose to over the intended dose by 30 percent.

MARK SEDDON: The verbiage you had before.

CLARK ELDREDGE: That was the language that I had drafted that I forgot to include in this.

MARK SEDDON: Right. That would make sense.

CLARK ELDREDGE: That would kind of address the situation.

MARK SEDDON: Right. That makes more sense. That's easier to quantify than something like this.

RANDY SCHENKMAN, CHAIRPERSON: Than a risk.

MARK SEDDON: Than just a risk.

CHANTEL CORBETT: Across-the-board basis where everybody is going to read it the same, be able to calculate and compare this.

MARK SEDDON: Because your risk is very patient dependent.

ADAM WEAVER: The second one, organ area, are

you talking about like if you're in a cardiology setting and you get the reddening of the skin, that may be more patients?

CLARK ELDREDGE: Well, I mean, if you're expecting to -- if you, you know, if you're doing a cardiac, if you are doing cath lab or something, you know you're going to be causing a certain dose that you're intending for the procedure, you know what your procedure thing, for some reason, oh, shoot, you know, no, we did not intend to call erythema dose and you do, then --

ADAM WEAVER: The problem with that is, you know, if you had a procedure at the other hospital two days ago, you didn't get reddening of the skin, but two days later, he's going to have another procedure and it is going to be reddening, it may not always be from a new facility.

MARK SEDDON: Or if you have temporary inflammation because of, for multiple CT scans and then you have --

ADAM WEAVER: Right.

MARK SEDDON: -- cardiovascular type of procedures.

ADAM WEAVER: Could be other factors could affect the skin.

CLARK ELDREDGE: Well, that's part of why the doctor has to look and say why.

ADAM WEAVER: But there's no way to track doses within the state. They may track it for the procedure, but they may not put that into the person's record, not have it for a doctor to look at.

MARK SEDDON: I mean, we are tracking. The facilities are tracking skin injuries from interventional procedures. That's kind of something that's --

ADAM WEAVER: But if a patient came from another facility, from another hospital.

MARK SEDDON: Right. It's always like who is at fault.

ADAM WEAVER: Right.

CHANTEL CORBETT: Right. I mean, you can have the cumulative dose.

MARK SEDDON: Yeah, it's cumulative dose over six months.

ADAM WEAVER: Right.

MARK SEDDON: You know, if you happen to be the one facility that captures it, and all the other procedures are performed, no one else captures it, so who really is the -- if you don't tie this to a

medical event, it's like, well, is it, you know -- he had what would be a fairly low-dose CT scan, but that caused an effect because this patient had previously had, you know, all these other cardiac interventional procedures.

ADAM WEAVER: He could've been in a CT or could've had a nuclear medicine procedure before that. Who knows. Acupuncture is something else that could cause reddening of the skin.

MARK SEDDON: Yeah. A long-time medications cause skin sensitivity.

ADAM WEAVER: Right. Allergic reactions.

MARK SEDDON: Is that the intention to have, this be used for some type of reporting for diagnostic procedures?

ADAM WEAVER: Putting it in the definition.

CLARK ELDREDGE: Putting it in the definition, yeah. As I say, it's trying to figure out if what, you know, again, looking for more bases of what, what is harm versus the blanket statements we're being provided in medical, in therapy -- or excuse me, medical event reports. And it's like, yeah. It's almost as vague on their part with no standard of what they meant by that, you know.

MARK SEDDON: Right.

CLARK ELDREDGE: And so --

MARK SEDDON: I think they may throw that -- a lot of times, they put the statement of no harm because of the, one of the criteria for medical reporting is permanent functional damage.

CLARK ELDREDGE: Right. I think that's what they're limiting it to.

MARK SEDDON: They're saying we don't have permanent functional damage.

CLARK ELDREDGE: For damage, but they are not, yeah.

CHANTEL CORBETT: You're saying it's not intended or expected.

CLARK ELDREDGE: Right.

CHANTEL CORBETT: Some of the things, obviously --

CLARK ELDREDGE: You know you're going to --

CHANTEL CORBETT: It's expected.

CLARK ELDREDGE: Right.

RANDY SCHENKMAN, CHAIRPERSON: Well, the patients also sign a consent form and a lot -- most of the consent forms have some of the known side effects in them.

CLARK ELDREDGE: Right. And that would, you know, if it's a known side effect, then it's not

a --

RANDY SCHENKMAN, CHAIRPERSON: It's not an intended or unexpected, yeah.

CLARK ELDREDGE: Right.

RANDY SCHENKMAN, CHAIRPERSON: So what does everybody think of this one? Do you like the first two paragraphs and not the third? All three? One?

KATHY DROTAR: Definitely not three.

MARK SEDDON: Yeah. I don't think three is something that would be easily defined. Number one definitely makes sense.

ADAM WEAVER: I think number two needs work.

MARK SEDDON: Two might need more work. Including diagnostic procedures, that becomes --

ADAM WEAVER: It's so wide organ or whole system.

MARK SEDDON: Yeah. Because now suddenly, if you use this logic, you're now creating a brand-new category of medical events in the interventional world, which never in the past had been medical events. Because you're seeing diagnostic procedures that result in some type of temporary skin damage. They're now considered a medical event, which is something that's brand new, no one else has done that before.

CLARK ELDREDGE: Unless it's an anticipated side effect of the procedure or --

CHANTEL CORBETT: I think the problem with interventional, a lot of these times these cases are not expected to get complicated; sometimes they do.

MARK SEDDON: Yeah, right. Because they go in and they start the procedure and it --

CHANTEL CORBETT: It changes.

RANDY SCHENKMAN, CHAIRPERSON: And some -- they find things they didn't expect to.

ADAM WEAVER: They find something else blocked and it takes a lot more time.

CLARK ELDREDGE: Time, right. But at that point, wouldn't that be just a continuation of the -- if the procedure has to go longer, well, that's the risk. They know, they say, okay, we have to run through this longer through the block, that means that would be an anticipated effect.

MARK SEDDON: Right.

CHANTEL CORBETT: I guess it depends on what your definition of when they're anticipated. Like, do we get to change that anticipation throughout the case?

MARK SEDDON: Because at the end of the case, they know the dose they gave.

CLARK ELDREDGE: I mean, I think that's part of medical practice is your anticipated outcome changes throughout the treatment of a patient.

CHANTEL CORBETT: Right. That's why I'm saying, that definition is hard --

ADAM WEAVER: Number two is really hard to --

CHANTEL CORBETT: -- as is.

CLARK ELDREDGE: All right. Work on it.

Next. Okay. Vendors. Our statute that register -- that requires the registration of vendors just says we -- the state shall register them and that's it. Okay? So, basically, everything we do with the registration is voluntary on the part of the registrant since we have no real standards in the statutes.

We have plenty of people in our list that have gone away and closed up and as it is, they're still registered. So trying to set a date for how long these vendors are registered. That they have to update us and let you know to keep the registration is part of the purpose of this.

So the current language in our rule just says who's supposed to register, who installs machines, service of machines, and the servicing includes fixing machines and all the components and adding

them and the form they have to respond with.

So what we're looking at saying is, okay. Actually, I rethought this again. It probably doesn't need to be -- valid may not be appropriately, may not actually be legally supported by or something about the fact that you can only be listed as registered. I might have to change that language rather than valid to something like you can only be listed for two years as registered.

And that they have to resubmit every time they want to do an update, they fill out another form so we know they are still out there and still a legal business. To help the community, since our registration doesn't -- currently, we don't really ask any question of what they actually do. It says, are you servicing machines, are you selling machines? But that doesn't help the actual medical community or the -- the people out there and us know what the service is through our registration. That, to me, seems like it's not benefiting everybody else in the state who's using these people if you don't know what they actually are there for. Because we do get questions from the public. How do I find somebody who services dental machines or this machine or that and we go, our only choice is going

to say, well, look, at the yellow pages, but if we ask them what services they provide a little more specifically, we'd have that as a resource for them.

So we'd ask them what categories, according to our listing, do you service, do you sell. Are you actually a specifically authorized vendor or for a particular brand; that type of thing. So that would also potentially give people some sort of, you know, and as well as for the services.

So this is just a kind of who are you, where are you, and remind us every two years to make sure you're out there or we pull you off the list.

Comments?

ADAM WEAVER: I don't know how this is going to fly through your -- it's like the state's going to put out a list and say, here are the vendors.

CLARK ELDREDGE: The list is out there.

ADAM WEAVER: It's out there now?

CLARK ELDREDGE: It's out there now. It is a legal -- we have to collect that. It's in the statute. People who do it have to give us this.

ADAM WEAVER: It's available on your website that you can --

CLARK ELDREDGE: You can get it by request. We don't --

CHANTEL CORBETT: I'm assuming that there's some caveat that says we're not, you know, we're not recommending.

CLARK ELDREDGE: We don't recommend and we still don't recommend anybody. But before anybody can walk into anybody's facility here to touch their radiation machines, they have to be registered with us. Before they can walk in to sell you one or call you on the phone, they are registered with us. But there's no --

ADAM WEAVER: I mean, yeah.

CLARK ELDREDGE: I'm just trying to make that --

ADAM WEAVER: You can buy x-rays now off of EBay.

CLARK ELDREDGE: Which again, it's illegal for them in Florida to sell you off EBay, but that's not going to stop them.

ADAM WEAVER: Right.

RANDY SCHENKMAN, CHAIRPERSON: This also doesn't specify whether after two years, they're going to have to repay for their registration.

CLARK ELDREDGE: There is no fee in the statute. They just have to register. We don't charge them for anything for that part of it. But

that's the next slide, which we'll stop after the vendors so we can move on to the next thing.

CHANTEL CORBETT: That would be the down side for the state as far as work load goes.

CLARK ELDREDGE: It's an unfunded mandate right now.

CHANTEL CORBETT: Yeah.

CLARK ELDREDGE: So should we be asking for more information that you all can use about them when they register? It's a loaded way to say that. I apologize.

ADAM WEAVER: Especially for the service part.

CHANTEL CORBETT: Yeah, it depends on how detailed you wanted to get on that, because --

CLARK ELDREDGE: It will be simple. I mean, we can't put that much detail for our side of it. But it would be, you know, at least you'd know that, we already know Henry Shine sells dental -- services dental, but at least it actually told us officially it's dental, not just service an x-ray machine. And we know that they represent --

ADAM WEAVER: What type of dental machine? Is it just an intraoral?

CLARK ELDREDGE: Right. We have our list of devices.

ADAM WEAVER: The CT ones that they're pushing.

MARK SEDDON: So is there a caveat, like, for service providers or installers that you guys would say that, you know, we're not blessing these people saying they're qualified?

CLARK ELDREDGE: We have no way not to. That's the other part of it. By having them offer us a little more information that is a way of them kind of proving their qualifications, especially if they say, I've been trained and authorized by Bob's or GE, Logic to work on.

MARK SEDDON: Right.

CHANTEL CORBETT: So what's the current requirement to be accepted? Just that you submit a form?

CLARK ELDREDGE: Here. You want to fill out the form, you can be registered today. Give me the piece of paper and you're gold. So that's --

CHANTEL CORBETT: No extra work.

ADAM WEAVER: I can install x-ray machines then.

CLARK ELDREDGE: So it's a, it's a -- this is just a way to give people more tools to be able to determine who they're dealing with.

CHANTEL CORBETT: Well, I mean, if the list was

more detailed, in the end, it might reduce the amount of questions you guys get at the state. So that would help them kind of guide to fewer people to call maybe. But redoing it every two years would increase the work, from what I'm hearing.

ADAM WEAVER: You're relying on these people being totally honest with you, saying I'm qualified to work on this GE machine. Actually, it was the last model.

CHANTEL CORBETT: But that's the way it's been.

MARK SEDDON: It already exists. You've got to figure out how to clean it up; make it better.

CLARK ELDREDGE: Make it better for everybody involved.

CHANTEL CORBETT: Right.

CLARK ELDREDGE: They can get people who want their specific business to call them and not deal with people who don't and --

MARK SEDDON: You can't make it go away because it's the statute. So you have to, right?

CHANTEL CORBETT: I mean, basically, as long as the statement is on there, please do your due diligence concerning their qualifications, blah, blah, blah. That's going to already be there, so, yeah.

CLARK ELDREDGE: That totally is there.
ADAM WEAVER: This is not a verified list.
RANDY SCHENKMAN, CHAIRPERSON: Okay. So is there anybody who does not want this?
(No response)
CLARK ELDREDGE: I think the consensus approves.
RANDY SCHENKMAN, CHAIRPERSON: Not one. Okay. Okay. It's 3 o'clock. So we're supposed to be ending and Brenda still has more to talk about. So what does everybody want to do?
ADAM WEAVER: I was wondering maybe if you could send these changes.
CLARK ELDREDGE: We can e-mail you.
ADAM WEAVER: Is that something you can do?
RANDY SCHENKMAN, CHAIRPERSON: That would be a really good idea. And then we can give you our comments.
CLARK ELDREDGE: Okay.
RANDY SCHENKMAN, CHAIRPERSON: Is that okay with everybody?
MARK SEDDON: Yes.
CLARK ELDREDGE: Sounds good to me.
RANDY SCHENKMAN, CHAIRPERSON: Brenda? Your turn.

BRENDA ANDREWS: My turn. Okay. My part is pretty brief. If time permitted, I wanted to talk more about our travel issues because I am trying to streamline and figure out where we're having our glitches and our problems and those who have been successful, just to get an idea of if it's all the system or if it's maybe passwords that aren't being put in to the standard or if it's -- just trying to find out where the problems are. But that will have to wait until another time. It's taken up a lot of your time and my time to try to figure out this system. Some people are getting approved; some people are not.

I want to talk about the communication between myself and council members. I feel like there's a lot of times that I can't get through or we don't communicate back and forth so that I can help get things done that need to be done. So that's -- but that's going to have to wait for another time.

The main thing I really wanted to talk about was the appointments and reappointments. As we have discussed, we have a new member, Dr. Plaxton, and we're happy to have him on board for another -- for a three-year term. His term will end on March 7th, 2021.

Also, Dr. Cognetta was reappointed. He was not able to be with us today because of a prior -- a commitment, but he has been reappointed. And the person who is not registered as a radiologist, you know that long term. The long one. But he will be with us probably with the next meeting. His term will also end on March 7th, 2021.

We have nine council members whose terms are going to end July 9th. And most of you I have heard from who want to be reappointed or apply for reappointment. You know, we have discussed how the system works now. There has been no change in the fact that we don't automatically reappoint people. They have to go through the same vetting process and the opportunity is opened up through the societies for nominees.

If you do tell me that you want to be considered, that is included in the letter that goes out to the societies and we let them make those decisions.

So right now, I will be sending out society letters, probably between the end of this week and next week. My goal is to have everybody vetted by the second week in June -- which is a quick turnaround time -- but since the Surgeon General's

office likes to have at least 15 days to a month to review everything and we have quite a few council members right now that are coming up -- it's usually one or two. This is probably the biggest group we've had for reappointments ever.

So I want to thank you all for your submissions and I will be processing those between this week and next week. Any questions on that?

The other part we have to do is to plan for the next -- the upcoming meeting. In the back of your packages are calendar -- oh, one more thing. I have included in your packages the updated list of council members. That includes Dr. Plaxton on here and Dr. Cognetta's reappointment. So if anything has changed or anything needs to be added for this, please let me know. You just send me an e-mail.

So we have calendars for September through November. It just gives us three months out to look at.

RANDY SCHENKMAN, CHAIRPERSON: What's your preference?

BRENDA ANDREWS: We've been doing them in September and May. It seems to be a good time -- a good month for everyone. So we can start with September to see if there's a date in there that

looks good for everyone.

Labor Day is on the 3rd, which is a Monday, and then we have the 11th, 18th and the 25th of September.

RANDY SCHENKMAN, CHAIRPERSON: So does anybody have any dates they know they're not going to be available on those dates?

STRATIS LAGOUTARIS: Okay with me.

RANDY SCHENKMAN, CHAIRPERSON: Okay. So what's best for you guys? Does it matter?

BRENDA ANDREWS: It won't matter to me.

RANDY SCHENKMAN, CHAIRPERSON: Okay. Does anybody have a preference?

CHANTEL CORBETT: How about the 18th?

BRENDA ANDREWS: The 18th, mid month? Okay.

CHANTEL CORBETT: Why not.

BRENDA ANDREWS: September 18?

RANDY SCHENKMAN, CHAIRPERSON: Is that okay with everybody, September 18th?

BRENDA ANDREWS: Okay. Very good.

RANDY SCHENKMAN, CHAIRPERSON: Okay.

BRENDA ANDREWS: Thank you.

RANDY SCHENKMAN, CHAIRPERSON: Okay. So do we have a motion to adjourn the meeting?

WILLIAM ATHERTON: So moved.

KATHY DROTAR: Second.

RANDY SCHENKMAN, CHAIRPERSON: Okay. Have a great day, everybody. The meeting is adjourned.

BRENDA ANDREWS: Thank you.

(Proceedings concluded at 3:03 p.m.)

CERTIFICATE OF REPORTER

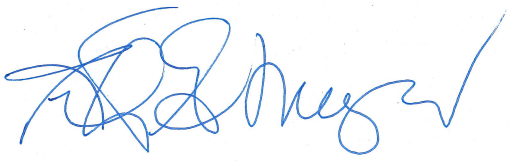
STATE OF FLORIDA:

COUNTY OF HILLSBOROUGH:

I, RITA G. MEYER, RDR, CRR, CRC, do hereby certify that I was authorized to and did stenographically report the foregoing proceedings and that the foregoing transcript is a true and correct record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties, attorneys or counsel connected with the action, nor am I financially interested in the outcome of the action.

DATED this 4th day of June, 2018.



RITA G. MEYER, RDR, CRR, CRC