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ADVISORY
COUNCIL ON
RADIATION PROTECTION

Bureau of Radiation Control
Hampton Inn & Suites
Tampa Airport Avion Park Westshore
Tampa, Florida 33607

Tuesday, September 19, 2023
10 a.m. - 3:06 p.m.

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



1 ADVISORY COUNCIL MEMBERS PRESENT:

2 Randy Schenkman, M.D., Retired (Chairman)
3 Mark S. Seddon, M.P., DABR, DABMP (Vice-Chairman)
4 Nicholas Plaxton, M.D.
5 Adam Weaver, MS, CHP
6 Chantel Corbett, AS, CNMT, RT (N), RSO
7 Joseph Danek, CHP
8 Jennifer L. Peterson, M.D.
9 Kathleen Drotar, Ph.D., M.Ed., RT. (R) (N) (T)
10 Albert Tineo, MS, CNMT
11 Luis A. Rodriguez Anaya, DPM
12 Armond B. Cagnetta, Jr., M.D.

13

14 FLORIDA DEPARTMENT OF HEALTH STAFF
15 BUREAU OF RADIATION CONTROL:

16

17 James Futch, Environmental Administrator
18 Clark Eldredge, Interim Bureau Chief
19 Kevin Kunder, CNMT, RT(N), Administrator
20 Brenda Andrews, Business Consultant
21 Jorge Laguna, Environmental Administrator
22 Kenneth Barnhart, Environmental Consultant
23 Camilla Guy, Environmental Specialist

24

25 GUEST SPEAKERS:

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27 Debbie Gilley
28 Hailey Kirbach - 4DMedical

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1 RANDY SCHENKMAN: Welcome. Why don't we start
2 with everybody telling everybody who they are. And
3 we'll start at that end of the table.

4 ARMOND COGNETTA: Armond Cognetta, Tallahassee.
5 Dermatologist.

6 ALBERT TINEO: Albert Tineo, Halifax Health,
7 Daytona Beach.

8 KATHLEEN DROTAR: I'm Kathy Drotar, Keiser
9 University. Radiologic Technology Program Director
10 and representative of the Florida Society of
11 Radiologic Technologists.

12 LUIS RODRIGUEZ: Luis Rodriguez, podiatrist in
13 Miami. I'm from Barry University.

14 KEVIN KUNDER: Kevin Kunder, radioactive
15 materials at the Department of Health.

16 DEBBIE GILLEY: Debbie Gilley. Debbie Gilley.
17 (Laughter)

18 DEBBIE GILLEY: Most of you know me anyway.

19 CAMILLA GUY: Camilla Guy. I'm an ES3 with the
20 Department of Health.

21 CLARK ELDREDGE: Clark Eldredge, interim bureau
22 chief, Department of Health, Bureau of Radiation
23 Control and administrator of the radiation machine
24 section.

25 RANDY SCHENKMAN: Randy Schenkman, retired

1 radiologist, and I worked at Baptist.

2 JAMES FUTCH: James Futch, radiation control
3 administrator and technology, CE, ionizing, whatever
4 else Clark can think of.

5 MARK SEDDON: Mark Seddon, medical physicist
6 from Advent Health Orlando.

7 BRENDA ANDREWS: Brenda Andrews, with
8 operations and management of the Bureau of Radiation
9 Control.

10 ADAM WEAVER: Adam Weaver, University of South
11 Florida.

12 JENNIFER PETERSON: I'm Jennifer Peterson. I'm
13 a radiation oncologist at Mayo in Jacksonville.

14 JOSEPH DANEK: Joe Danek, retired consultant
15 with Florida Power and Light, NextEra Energy nuclear
16 program, environmental expert.

17 CHANTEL CORBETT: Chantel Corbett from Fusion
18 Physics. Nuclear medicine technologist
19 representative.

20 JORGE LAGUNA: Jorge Laguna, Bureau of
21 Radiation Control. I'm in charge of the inspection
22 section. We have somebody in the back.

23 KENNETH BARNHART: Kenneth Barnhart,
24 environmental consultant, wallflower.

25 (Laughter)

1 RANDY SCHENKMAN: And we'd like to recognize
2 Dr. Rodriguez and welcome him. He's our new member.

3 LUIS RODRIGUEZ: Thank you.

4 RANDY SCHENKMAN: Okay. Now we need to approve
5 the minutes from our meeting on Thursday, May 18th.

6 ALBERT TINEO: So move.

7 CHANTEL CORBETT: Second.

8 RANDY SCHENKMAN: All in favor, say aye.

9 ALL: Aye.

10 RANDY SCHENKMAN: Any opposed?

11 (No Response)

12 RANDY SCHENKMAN: Okay. That is approved.

13 And now Clark, your turn.

14 CLARK ELDREDGE: Okay. Well, the Bureau's
15 doing all right right now. No major concerns.
16 We've been averaging 13, 15 vacancies at any given
17 time for a while now. We get positions filled and
18 people leave. So we actually have, you know, since
19 we have 94-and-a-half positions in our Bureau,
20 that's not a very good vacancy rate of, you know, 15
21 percent or so.

22 Activities, the Bureau's continuous work with
23 training emergency response agencies on detection
24 response radiation sources and hazards. Just for
25 the previous meeting, we had -- we provided training

1 with hazardous materials response teams from the
2 FBI, National Guard and some fire -- local fire down
3 in the Orlando lab.

4 Today -- actually today, we're hosting another
5 session with NASA, FBI, National Guard personnel at
6 the Orlando lab. And so, yeah, we continue our
7 partnership with all the other agencies on radiation
8 safety and protection for the public.

9 Our PRND, preventive radiological nuclear
10 detection activities continue. Our most recent
11 event was the Coke 400 the end of August in Daytona.
12 The next one coming up we'll be providing security
13 for radiation protection is the International Boat
14 Show in Fort Lauderdale and that's the end of
15 October.

16 Rule adoption and development for the Bureau.
17 Some specifics will be discussed in program updates.
18 But with our -- due to the current number, you know,
19 there are a lot of levels of rule review in place
20 with the Department of Health and other state
21 agencies right now. A whole stack and layers. So
22 our counsel has now suggested that we submit rules
23 in the smallest possible chunks and pieces that are
24 coherent to speed up the process.

25 This year was a one -- was our periodic audit

1 by the U.S. Nuclear Regulatory Commission for our
2 materials program. It's the Integrated Materials
3 Performance Evaluation Program, IMPEP. This review
4 brings a team of NRC and agreement state program
5 personnel to us. They go out with our inspectors,
6 they come into our headquarter's office, and they
7 review our files and our procedures and policies and
8 things like that.

9 The review went well. The details will be
10 covered in the material programs update. But
11 overall, the materials group did a great job and the
12 inspection team working on that.

13 I guess that's it left over -- oh, position
14 openings, where's that one? Okay. I lost my
15 details on that because I talked about we've got the
16 15 positions open, but I was going to go over the
17 breakdown for the areas. I put that somewhere funny
18 in my notes.

19 Okay. Here it is. So, inspections, down six
20 folks right now. They've had, of course, the four
21 regions. One of them is a staff specific, the other
22 five are field folks. Materials programs has got a
23 reg specialist. They've got a position they have
24 open and it's a person who does on the general
25 licensing, correct?

1 KEVIN KUNDER: Yes.

2 CLARK ELDREDGE: General licensing.

3 Environmental radiation, the Orlando lab folks are
4 down a chemist and three ESEs and most of those are
5 in the environmental monitoring group and power
6 plant monitoring group.

7 Technology, James has got his government
8 operations consultant position open. Actually, it's
9 his programmer and an environmental consultant. And
10 in the x-ray program, we've got the -- our
11 environmental health program consultant position
12 open. And, of course, the bureau chief position is
13 still -- hasn't been filled permanently.

14 So next coming up is going to be --

15 RANDY SCHENKMAN: Okay.

16 CLARK ELDREDGE: -- Ms. Gilley.

17 RANDY SCHENKMAN: Yes.

18 CLARK ELDREDGE: I had a little statistics from
19 that to preface before we do her introduction. Do
20 you have to --

21 JAMES FUTCH: I think Brenda wanted to bring up
22 something that needs to be addressed because it's
23 been three years.

24 BRENDA ANDREWS: Yes. Actually, a little bit
25 longer than three years.

1 The last time we updated the bylaws, we agreed
2 that the chairman and co-chairman positions would go
3 from one year's term to three years. And so that
4 three-year term for the current people in the
5 positions was in May of 2022, I believe.

6 So we decided we needed to bring this up now so
7 that we can give the opportunity to vote on the
8 current ones -- people who are here, or if we want
9 to nominate someone new. I want to say that both
10 have shown interest or expressed interest in
11 continuing to serve as chair and co-chair. But at
12 the latter part of the day, we will do a vote on
13 that. So just keep that in mind for the rest -- for
14 the day.

15 JAMES FUTCH: Not speaking presumptuously, you
16 guys are interested, I have heard, in continuing to
17 serve.

18 MARK SEDDON: Yes.

19 RANDY SCHENKMAN: Yes. Okay. Now we will go
20 on to let Clark finish and then we'll go to Debbie.

21 CLARK ELDREDGE: The Department of Health has
22 2,160 veterinary registrations, 3,582 machines;
23 2,107 are vet radiographic. We've got 1,055 vet
24 dental; 294 vet portable radiographic machines for,
25 you know, large animals; things like that, to carry

1 them around. 71 vet CTs; 15 vet fluoros. Two
2 treatment planning systems as registered in the
3 database. One combined fluoro radiographic. We
4 also have vet radiation therapy registrations is
5 separate.

6 Four of these veterinary radiation therapy
7 facilities are registered as industrial with seven
8 accelerators. Six have registered as medical under
9 the medical accelerator standard with eight
10 accelerators.

11 So the difference between a veterinarian
12 deciding to register their therapy as industrial
13 versus medical is that both registrations address
14 components of protection for the public and workers.
15 The medical registration actually includes
16 components that address treatment standards for the
17 patient.

18 So that's the current sort of status in numbers
19 of what's happening with us. As I say, the -- for
20 the accelerator folks, you know, when they actually
21 have a medical registration, they have to have
22 treatment planning, you know, medical physicists
23 doing treatment planning for the animals; things
24 like that. If they don't have that, they're up to
25 their own, what they consider best practice

1 standards and I guess the standards published by --
2 there are -- I can't tell you the -- I should have
3 written those down -- about two or three veterinary
4 medical therapy groups out there and it will be
5 their practice standards that the folks follow.

6 We recently had a call from somebody who was
7 rather upset that when their 16-year-old cat went
8 through radiation therapy, it quickly after that had
9 lost its kidney function and succumbed from that.
10 But you have to ask that, it's a 16-year-old cat
11 and, you know -- so, you know, people deal with
12 these types of things on the human level in this
13 type, you know, as any other area with their pets.

14 JAMES FUTCH: So while we're getting set up for
15 Debbie's talk, you have a sheet of paper about lunch
16 in front of you. If you would like to make a
17 choice, we're going to collect these and Brenda is
18 going to get them taken over so we're a little
19 farther ahead when we get there.

20 CHANTEL CORBETT: Don't forget to circle your
21 drink like we did last time.

22 DEBBIE GILLEY: I'm glad this wasn't the first
23 time since I didn't do it. You all did it last time
24 without me, so --

25 CLARK ELDREDGE: One more thing. All right.

1 While you all do that.

2 DEBBIE GILLEY: I sent it to you in an e-mail.

3 CLARK ELDREDGE: I know you sent it to me in an
4 e-mail.

5 DEBBIE GILLEY: This is going to just work,
6 right?

7 CLARK ELDREDGE: Well, Ms. Gilley is an
8 esteemed colleague of ours who has many years of
9 experience in radiation protection. She has --
10 she's a radiation therapist initial training; is
11 that correct?

12 DEBBIE GILLEY: Yes. A long way from radiation
13 therapy.

14 CLARK ELDREDGE: She made -- she decided to go
15 into public service working for the Bureau of
16 Radiation Control and take one for the greater good.
17 She was actually went and was in charge of training
18 program for -- our entire training program for
19 radiation for all of our health physicists and
20 whatnot in the Bureau.

21 She decided to leave us and go work for the
22 International Atomic Agency, IAEA in Vienna, where
23 she was involved with developing training programs
24 and other practice standards and stuff around the
25 world. Visiting various countries and helping them

1 adopt radiation protection practices.

2 She has worked with the AAPM on an ad hoc basis
3 for a little while as their government liaison. She
4 is a font of knowledge in some areas (laughter).

5 And we really appreciate the service she
6 previously gave the Department of Health.

7 DEBBIE GILLEY: Ready?

8 CLARK ELDREDGE: Ready. Go for it.

9 RANDY SCHENKMAN: It's all yours.

10 DEBBIE GILLEY: Great. Thank you first for the
11 opportunity to come and talk to you. I've had a
12 very rewarding career in my lifetime. I worked in
13 health care for ten years, in radiation oncology. I
14 got to work 24 years for the Bureau of Radiation
15 Control doing a host of many different things along
16 the way. And then fortunately, in August of 2011, I
17 got invited to work for the International Atomic
18 Energy Agency, which was never in my dreams. It
19 just kind of happened. But it was a wonderful
20 opportunity to see how the rest of the world works.

21 While I was there, I was assigned several
22 different tasks. One of those tasks was to develop
23 a safety report on radiation protection in safety in
24 veterinary medicine. For us in this country, it's
25 been well established. We've had veterinarians for

1 many, many years. We take really good care of our
2 pets, but for the rest of the world, many of them
3 whose incomes and standard of living are moving up,
4 having pets is now something they can afford to have
5 and having care for their pets is something they can
6 afford to have. And many of those countries did not
7 have any type of regulations to address radiation
8 protection and safety in veterinary medicine.

9 So we started on this project in 2017. It was
10 finally published in 2020. It's a much harder to
11 get an international publication out than it ever
12 was to get regulations out of the State of Florida
13 and we all know how hard it is to get regulations
14 out of the State of Florida.

15 So, anyway, it's my pleasure to be here with
16 you. I'm going to talk a little bit about
17 veterinary medicine. I think most of you here in
18 the room are more familiar with human medicine and
19 you'll see a lot of similarities and then I'll talk
20 about some of the differences.

21 The whole point of this is that we saw improper
22 procedures being performed, improperly trained
23 individuals doing veterinary medicine. They don't
24 have the same history and standards for training
25 that we have for human radiation procedures.

1 The purpose is to get some observations,
2 considerations, general recommendations. Primarily,
3 we were looking at radiation protection
4 professionals. We were looking at veterinary staff,
5 students, educators that provide training,
6 regulators, members of the public. And then we also
7 needed to consider anybody that does, if you're not
8 familiar, there is a subset of people that
9 manufacture veterinary equipment. Many of it is
10 used equipment that comes out of the human aspects
11 that go into veterinary medicine, but there are some
12 specially designed veterinary equipment, such as the
13 large field-of-use CT scanners.

14 They do everything that you see in a medical
15 environment. You will see the diagnostic imaging,
16 the x-rays, they have CT scanners, they have MRI
17 scanners. They do nuclear medicine studies, more
18 than just iodine CAT therapy, which we have had a
19 history in Florida about for -- before I ever left.
20 And so you'll see that they do a lot of simulation
21 with horses, looking at knees and those kind of
22 things.

23 The one thing that is different is that you
24 really can't expect the cooperation of your animal
25 like you would hopefully have the cooperation of

1 your patient. So you have to use more
2 immobilization devices and you have to have,
3 sometimes have horse whisperers in the rooms to keep
4 the horse calm. Sometimes you have to blind their
5 eyes so they don't see what's going on in order to
6 keep them from being agitated.

7 So the purpose of the publication was for
8 worker protection primarily.

9 Part of the reason for this is that the
10 International Atomic Energy Agency develops basic
11 safety standards and their basic safety standards is
12 very specific. That patients are only human beings,
13 so we can't call animals patients. And they don't
14 adhere to the same level of protection that we would
15 use for a human. And I will get into a little bit
16 more of that later on.

17 Again, as I said, we see it growing
18 considerably. I was just in Romania in May helping
19 that particular government organization develop
20 regulations for veterinary medicine because they
21 have nothing and they have limitations in their
22 current regulations that would prevent them from
23 being able to offer this service.

24 We had another meeting in Albania last year,
25 the same things. These countries are starting to

1 need to have some regulations in place so that
2 radiation is handled properly for veterinary
3 medicine.

4 Here is the guide. ICRP has a new thing out on
5 the ethical treatment of animals. This is brand
6 new. It was just out maybe three months ago. I
7 suggest if you want to look at the ethical treatment
8 of animals, which is not covered in the radiation
9 protection and safety veterinary medicine
10 publication from IAEA, that you can look at this
11 one.

12 This is why we develop this guidance. That is
13 someone's hand holding an animal for an x-ray. This
14 is the reason why we need to have some regulations
15 and training and education for the individuals that
16 are providing these services.

17 I can show you other examples. I could've
18 picked a whole handful when I started this project.
19 I had lots of people sending me photos, but I think
20 this one kind of demonstrates the importance of
21 radiation protection in this component.

22 A little bit about the IAEA and how the rest of
23 the world works. The U.S. does not subscribe to the
24 basic standards of the International Atomic Energy
25 Agency, but the International Atomic Energy Agency

1 does have regulations that other countries need to
2 adhere to in order to get any financial support from
3 IAEA. So they go through the process of creating
4 these things and they're good radiation protection,
5 wonderful fundamental radiation protection. More
6 important for places maybe in Europe where countries
7 are so close together that they have some
8 consistency with radiation protection from one
9 country to another.

10 For the U.S., it's Canada and Mexico for us,
11 but again, it's a much -- we're 344 million people.
12 We're kind of our own little Europe right here in
13 our own United States with 50 states having some
14 components of radiation protection. We function a
15 lot like the European Union does, but they're
16 different countries.

17 Anyway, we take our -- the effects of radiation
18 from UNSCEAR. I'm sure most of you should have
19 heard about that. They're the ones that kind of
20 determine how much radiation we're getting from
21 cosmic, from nuclear power, from medical. And we
22 take that information from them and ICR takes that
23 and ICR is the one that makes recommendations for
24 the IAEA.

25 Here in the United States, we have NCRP. That

1 is who is our -- we take our recommendations from
2 protection. They are not identical. They are
3 different. We do things differently here in the
4 U.S. Again, we have a large volume. We see things
5 before everybody else does, especially some of the
6 newer research that's out there because we're such a
7 large user of a lot of the stuff that has radiation
8 components in it.

9 They create these essential principles, moral
10 obligations to use radiation safely and then they
11 have the requirements. And the requirements for us
12 are the basic safety standards. And this
13 publication was finally approved by all of the
14 organizing -- organizations. World Health
15 Organization approves it, Labour approves it,
16 European Union approves it. A bunch of people. It
17 takes a long time to get these things approved
18 because they have to approve it in its entirety.

19 This was published in 2014 is the latest one.
20 It took about twenty years to develop this one. And
21 I would imagine that the next one when it's done in
22 another ten years, usually about ten years they go,
23 they will start creating another group of
24 individuals to revise the basic safety standards.

25 So these are the principles. These are the

1 core standards. This is what we aim for. This is
2 the hierarchy. All of these safety requirements are
3 underneath those safety fundamentals and then we
4 have a series of safety guides and then we have a
5 series of safety reports that are even further down
6 into this pyramid.

7 This is the one that we use mostly. There are
8 some just on nuclear power. There are others on
9 industrial aspects. There's some on uranium mining.
10 That's a whole host of things going on. Security is
11 a big issue. There's a whole section on security of
12 radioactive sources, so it's quite an elaborate
13 system.

14 Back to the BSS. You can see we started in
15 2007 with revisions. It finally got published in
16 2014. So that is the version that we would produce
17 any future safety guides or safety reports from.

18 So it's not mandatory, but it is if you want to
19 get any technical assistance from IAEA. This is the
20 guiding document we use in order to determine
21 whether or not a country is compatible with the
22 basic safety standards. The Bureau just went
23 through an IMPEP audit with NRC. It's basically the
24 same kind of event. They go and look and see if
25 you've met all the requirements in the BSS and that

1 you're operating in that method.

2 If you're not familiar with ICRP, this is just
3 how it's set up and this is what we use for
4 developing the veterinary medicine guide. We use
5 radiation -- veterinary medicine is a planned
6 procedure. We look at dose limits and dose
7 constraints for our workers. We do use the
8 principles of justification, optimization and dose
9 limitations in veterinary medicine. We are in the
10 occupational area, not the medical area for exposure
11 because we do not -- the basic safety standard does
12 not consider animals to be patients. And then we
13 have requisites, information, assessment of exposure
14 and stakeholder involvement.

15 This is the safety report. It's guidance.
16 It's not a requirement. It was developed so that
17 people would have some guidance in the process of
18 developing regulations and making sure that
19 radiation was used in veterinary medicine safely.
20 It addresses common radiation protection issues and
21 it's organized similar to another guide we have on
22 medical applications.

23 Because veterinary medicine mimics human
24 medicine, we have a section on diagnostic imaging, a
25 section on nuclear medicine and a section on

1 radiation therapy. Same as with our safety guide
2 for medical applications.

3 So there is some redundancy in it, but it's
4 easier for the user. They read, you know, Chapter
5 One. If they do diagnostic imaging, they just read
6 Chapter Three. If they do nuclear medicine, they
7 read Chapter One, Two and Three and Four and on and
8 on as such.

9 We do recognize it is used. It's classified as
10 a planned exposure and it meets the requirement for
11 a planned exposure. Those are just the references
12 from the safety standard.

13 So we are concerned with radiation workers,
14 that's veterinary assistants, animal handlers and
15 veterinarians. There are other people that
16 participate in veterinary medicine that we don't
17 normally see in human medicine. We are concerned
18 for the pet owner and the family and we're concerned
19 for the public areas where radiation exposures are
20 performed.

21 As you can see, we are doing an x-ray on a
22 Bengal tiger. This tiger has been anesthetized.
23 You want to get these things in and out. It's a
24 large animal. You have to have an appropriate table
25 that can accommodate that weight.

1 The next one I have is I believe a Komodo
2 dragon, some dragon they had to anesthetize in order
3 to take an x-ray. Again, here is one done at a zoo
4 of a giraffe. So you can see that we have some
5 challenges that we don't normally have in human
6 medicine.

7 It was initiated as part of our radiation
8 safety advisory committee which we have that is
9 similar to this advisory committee, except it's made
10 up from people from different countries. And we did
11 a consultancy to kind of outline what was going to
12 be on the document. The document was developed
13 following the guidelines of 2015. We got together
14 2016.

15 I will tell you one of the most impressive
16 things about working for the IAEA is I had some
17 really, really important veterinarians helping me
18 make this -- develop this training and they had some
19 really, really interesting stories and I had to
20 constantly pull them back from the story telling to
21 work on documents about writing regulations. And
22 I'll tell you a little about them at the end of the
23 presentation.

24 We edited it. We had a second consultancy to
25 finalize it. We presented it to RASSC in June of

1 2018 and we finally got it published in March of
2 2021. It should have been out earlier, but of
3 course, we had the pandemic in the process and work
4 just stopped for many of us, because we're not an
5 organization that's really set up to work remotely.
6 So it was a real challenge to get people back
7 working and getting the infrastructure in place for
8 them to work from home during 2020.

9 Okay. You'll see it's all about the same.
10 Many of the applications in radiation medicine are
11 being used in veterinary centers around the world.
12 And it provides the guidance that we think that they
13 need and we are seeing it in practice now.

14 I want to point out the photo, if you can see
15 it, it's a little bit dark, but it's a horse, but
16 look at the number of people that have to be there
17 for the exposure of that horse. It's far greater
18 than even a child if you put it in a Pigg-O-Stat to
19 do an x-ray. I mean, you just have a lot more
20 potential exposure to individuals. And these people
21 may or may not know how to wear protective
22 equipment. And they may or may not know not to
23 stand in the beam or behind the detector. They
24 don't necessarily know that because they are not
25 trained like our radiographers are in this country

1 or nuclear medicine technologists or therapists.

2 JAMES FUTCH: Debbie, in that picture, I don't
3 think anybody can see it. The horse, is that a lead
4 apron hanging down from the neck of the horse or is
5 that another person standing on the other --

6 JORGE LAGUNA: It looks like another person.

7 CAMILLA GUY: There's a person behind there
8 with a lead vest.

9 DEBBIE GILLEY: Yeah, you see the number. When
10 I was talking to the veterinarians that helped me
11 develop this, they were, they were, they were
12 telling me about have horse whisperers in there and
13 animal handlers in there and all these individuals
14 that in their normal duties are not ever exposed to
15 radiation.

16 You get out in the field where you're working
17 on farms, you may have farm hands that are asked to
18 come up. I mean I've seen -- they're not -- I have
19 lots of photos. I selectively pulled out photos.
20 But I've seen some bizarre ways of x-raying animals
21 and doing nuclear medicine studies with animals.
22 That was the other one that was quite fascinating.

23 Radiation therapy, they sedate the animal and
24 they do that in a fixed facility. That's not --
25 there's no mobile activities with that.

1 Okay. So here's a break up of the publication.
2 We have the general, we have general safety of
3 veterinary radiation facilities and occupational
4 and, this is just in diagnostic.

5 Nuclear medicine and radio therapy had the same
6 basic breakdown, except in nuclear medicine, we
7 talked about waste, because we have a waste
8 component in nuclear medicine, and we talk about
9 source security in nuclear medicine. And in
10 radiation therapy, we do the same. You will find
11 high dose rate afterloaders in veterinary practices
12 in some areas of the world. I don't think we have
13 one here in the -- in Florida.

14 Specifically, we're looking at addressing
15 occupational exposure, guidance, public exposure
16 guidance, pet owners exposure guidance, security
17 where applicable, and emergency response where
18 applicable. Spill procedures, theft; those kind of
19 things. Their emergency response procedures or
20 instructions on what should be completed.

21 For the radiation oncologist in the room, yes,
22 they do do treatment planning for these animals.
23 They have a treatment planning system they set up.
24 They use -- this is the place that I went to was the
25 veterinary university in Vienna, Austria to take a

1 lot of these photos. We did a little video on the
2 value of the veterinary safety guide that we were
3 able to film out there. They do have everything.
4 They have MRI, CT, Siemens 6MV linear accelerator
5 and they were treating a dog for a brain tumor at
6 that time. So fascinating. One of my favorite,
7 favorite jobs that I had to do there.

8 So here we are also at the veterinary school
9 there. This is nuclear medicine. They're doing a
10 scan on a cat. They also have to do animal release
11 when it's available to go and then proper disposal
12 of the waste.

13 Different subset of workers and defining what
14 type of training they needed. It's a little bit
15 more than need to know or what we require nuclear
16 medicine to do for their housekeeping service
17 because they are potentially being exposed to
18 radiation. We have to determine who is monitored
19 and who is badged and who is not. We try to make
20 sure that the same horse handlers, if they work for
21 a veterinarian, are not used all the time to do the
22 holding of the animal. And we needed different
23 instructions for pet owners. And I think Florida
24 has had some experience with, especially the thyroid
25 cat issues with pet owners and so it was important

1 for us to make sure we identified and shared that.

2 Again, the animal cannot follow instructions.

3 And my veterinarians said we're not that concerned

4 about the radiation protection. We're concerned

5 about being kicked in the head by a horse. So we

6 had to put things in perspective as to what is the

7 true threat for performing a procedure. For them,

8 it is an uncooperative animal. And with the

9 non-domestic animals, such as the tiger that had the

10 electron therapy on the first picture I did, they're

11 all anesthetized. And that doesn't always work as

12 well, according to my veterinarians, as these

13 pictures demonstrate. Sometimes the, the

14 anesthetist, the information agitates the animal, so

15 you have to be very conscious of what is going on

16 with that, and that is their priority is not to be

17 injured by the animal in the process of getting an

18 x-ray or doing a procedure.

19 So our, our differences for us in this area

20 from what we see in medicine is sometimes veterinary

21 medicines are in odd places. You may find them in a

22 stable. You may find them in a farm. It's not

23 unusual to see the x-ray machine, portable x-ray

24 machine being taken out to where the animals are.

25 Again, the value of that it's less agitation on the

1 animal than putting them in a trailer and taking
2 them in to the vet if they can get what they need
3 for that.

4 The animal handler was a new term for me. They
5 are people that manage and take care of these
6 animals. One of the ladies I worked with does all
7 of the thoroughbred race horses for Saudi Arabia and
8 animal handlers come with the animals when they come
9 to Belgium to be x-rayed. So they're not in Saudi,
10 they're in Belgium. And again, she had a whole
11 group of people that she's now responsible for that
12 didn't necessarily speak French, and she had to
13 provide protection for.

14 Here is in nuclear medicine, they put plastic
15 bags over the hoofs of the horses when they do a
16 nuclear medicine study with expectations that they
17 can limit the control of contamination. A lot of
18 waste associated in nuclear medicine with animals
19 because they can't control where the animal urinates
20 at. And then they put it in the straw to help with
21 absorption, so they have containers, containers of
22 radioactive waste just from a technetium study.

23 The other thing is here is imaging of a horse.
24 They blind the horse so that the horse is less
25 likely to be uncooperative. And they can't really

1 tell the horse to hold still, so they have to have
2 somebody there holding the horse still for that
3 image.

4 So we were fortunate, HERCA is the European's
5 equivalent to the CRCPD. They are the group of
6 regulators. They have radiation control authorities
7 in European and they had already addressed this
8 issue and I had Joline Berlamont from Belgium that
9 was on the committee, so we adopted HERCA's training
10 program and it gives a core training for the
11 veterinary surgeons, which is -- one other thing
12 about IAEA, the language of IAEA and all their
13 publications is the Queen's language. British
14 language. So they don't have a term for
15 veterinarians in UK. They're called veterinary
16 surgeons. So that's why they're called veterinary
17 surgeons through here.

18 Our protocols are French. That was another
19 whole learning advice for that. But the language is
20 English, but for publications, it's UK English. So
21 all the words are spelled the way the UK spells
22 them. So we call them veterinary surgeons because
23 that is what the UK referred to them as.

24 This training program goes through the
25 knowledge, skills and competencies for each of the

1 things that they need to do. It covers
2 justification optimization of procedures and
3 communication with animal owners. And again, the
4 relationship with the veterinarians is not with the
5 animal. It is with the owner of the animal. You
6 need to be very clear about that. Because we don't
7 have any dose constraints for animals in the process
8 of being x-rayed or nuclear medicine procedures or
9 therapy.

10 Okay. Then we have veterinary assistants and
11 veterinary radiographers. Here in the U.S., I did
12 call around looking for people and I had a lady from
13 University of North Carolina that was a radiation
14 safety officer for a veterinary university that was
15 also on our committee and a lot of the veterinary
16 radiographers are radiographers that used to work in
17 medicine. They do have proper training and they
18 just choose to, to you know, image animals over
19 humans. They've gone to work for veterinarians.
20 I'm sure it's maybe a easier job for them than what
21 they were doing in hospitals.

22 Here would we do see that happening. That's
23 not happening most every place else. These people
24 are being trained.

25 So again, the topics are there. Ability to

1 practice safely. Understanding and utilize the
2 practices to assure optimization of exposure.
3 Again, we talk about optimization and justification
4 is every time you have to hold an animal for a
5 procedure, we want to limit or reduce the dose to
6 that person that's having to do the holding. So
7 that's the optimization component of this. So if
8 you change and have a high kV, low mA imaging,
9 you're going to reduce the amount of radiation that
10 the person holding the animal is also getting.

11 Safe working environment and provide
12 instructions for animal owners and animal handlers.
13 So these knowledge skills and abilities are there
14 for interventional radiology, nuclear medicine and
15 radio therapy, the same as they are for diagnostic
16 imaging. And they're specifically to the type of
17 procedures that are performed in those specialties.

18 Okay. So one of the things that happened to
19 come up in the process of doing this is that we have
20 a reporting system, much like the US NRC reporting
21 system, where we have overexposure of workers is
22 reported to -- from radioactive materials and
23 reported to US NRC.

24 Here's a case where there's a national
25 reporting. It's called the INES system where

1 they're reported to IAEA. And it is -- you can, you
2 can subscribe to it. I still get the messages.

3 This is a veterinary clinic that happened in
4 Finland, where one of their nuclear medicine
5 veterinary operators was -- had some contamination
6 on their body and they went through the process of
7 determining what the exposure was and the pathway
8 and how it happened.

9 And again, it was I-131 from a cat thyroid
10 treatment and they managed to stroke the cat, maybe
11 when injecting the Iodine-131 in the cat, some of it
12 was left on the skin, was picked up by the operator
13 who then touched herself and moved on from that. So
14 there is value in having some instructions out there
15 to prevent this from happening. Of course, this
16 happened before the, before the publication was
17 completed.

18 A little bit about this. This is a Komodo
19 dragon that was being CT'd. A little bit about the
20 people that helped write this. Joline Berlamont was
21 my regulator. She -- no, Joline Berlamont was from
22 Belgium. They have a real good program there. John
23 Benoit is a radiation oncologist, veterinary
24 radiology oncologist trained at University of North
25 Carolina.

1 I didn't touch a button. Somebody else must be
2 running the show.

3 Amy Orders came from North Carolina State
4 University. They have a big veterinary university
5 up there. Trained a lot of veterinarians up there.

6 Kathleen Peremans was from Ghent University.
7 She had a very interesting history. Saudi Arabia
8 buys a lot of million dollar horses and she -- they
9 have a special plane, transport plane and they bring
10 them to Ghent University to get their medical
11 passport. So she was doing whole body horse CT to
12 look for any anomalies in the horse before they were
13 purchased by the sheiks of Saudi Arabia. So she's
14 got lots of stories. She was fascinating. I had to
15 keep reeling her in. We need to move on.

16 Renate Weller, she is from the UK and she is
17 the official Queen Elizabeth's veterinarian for the
18 corgis and the horses. And she's got the equivalent
19 of a knighthood, but they can't knight women. She's
20 got some other big award. Anyway, she was extremely
21 fascinating to hear her talk and how Princess
22 Margaret calls her up and she goes out to the
23 stables and takes care of the horses for Princess
24 Margaret and all that kind of stuff. Fascinating
25 woman.

1 And then we had a lot people from IAEA that
2 helped with actually the writing of it. I write
3 American style because I'm American. And so, I
4 fortunately had Darren Delves, who is from Scotland,
5 that finished the last publication, to make sure I
6 added the right Us and Ss to the British words that
7 needed to be added.

8 Again, fascinating thing. I think it would
9 have value. If you want to read it, it's freely
10 available you can download a copy of it from IAEA.
11 If you have any other questions about it, please
12 feel free to ask me about it. I've got lots of
13 stories and probably a lot more pictures of a lot of
14 different animals being x-rayed.

15 I was just in Australia and went out to
16 Melbourne and they were doing -- x-raying a
17 Tasmanian Devil. That was just fascinating to see
18 that. They were doing -- they were clipping them or
19 putting a chip in them so they could follow their
20 activities. They were going to be putting it back
21 into the wild at this recovery center.

22 Any questions? Anybody enlightened?

23 MARK SEDDON: So you're saying, is there an
24 equivalency in the U.S.? Do any of our NCRP have
25 something similar?

1 DEBBIE GILLEY: NCRP does have a 2004
2 documentation on veterinary medicine. It's pretty
3 outdated. We did look at it and used it. We did
4 reference it in this. In fact, it was the only
5 really publication for regulations, recommendations
6 that was available before we wrote this particular
7 one.

8 ICRP has since come out and wrote the document
9 on ethical treatment of animals in order to
10 complement what we were doing here. A lot of
11 interest, you know, I've been to the Philippines to
12 talk about veterinary medicine.

13 So I, I don't know that we have specific
14 regulations here for that. Where they do or they
15 are doing that in other countries. Romania had
16 written specific regulations for veterinary
17 medicine. They're in the process of getting them
18 promulgated through their process. Albania had
19 started drafting. I don't know where they are in
20 the process. But we don't have specific regulations
21 for this area.

22 I think we probably -- I don't know how we do
23 it to make sure that the veterinarian assistants,
24 radiographers are adequately trained to prevent them
25 from x-raying their arm -- or I didn't put the

1 picture in here, I have a picture of a veterinary
2 assistant sitting down with a detector on her lap
3 and the dog in her lap. And the, and the tube right
4 above her. She's holding it.

5 RANDY SCHENKMAN: Holding the --

6 JAMES FUTCH: Holding the tube.

7 DEBBIE GILLEY: She's holding the animal in her
8 lap. No lead apron at all. And this is what -- why
9 we wrote this. Is we can stop these poor practices
10 if we will just have, have people be aware and
11 knowledge and provide the training. The training
12 that is developed is very specific knowledge skills
13 and competencies in that area.

14 Forty hours I think is what Belgium was
15 requiring for just the basic assistant. Not the
16 radiographer, but the assistant. Because the
17 radiographer still needs to know about authorization
18 and kV and mA and coding and all that stuff. They
19 need a little bit more training on that. It's kind
20 of based on what your expectations are to be done in
21 that area.

22 You will have to ask the Bureau of Radiation
23 Control about how that goes in Florida.

24 CLARK ELDREDGE: We're not that detailed for
25 the training. The machines, we do have standards

1 for the machines, which basically, we want machines
2 maintained to human medical standards. FDA doesn't
3 require that the beam be filtered for medical, but
4 in Florida, for veterinary -- but in Florida we
5 require filtered.

6 MARK SEDDON: So the veterinary units in
7 Florida do.

8 CLARK ELDREDGE: Have the x-ray beam filtered.
9 So, basically, the idea for us is by, trying to
10 insure the image is to improved from the hardware to
11 reduce the exposure to the operators.

12 Not too long ago, we had someone come across a
13 Facebook post from a veterinarian practice, probably
14 within 30 miles of here, where it was a lizard. And
15 they had sets of hands holding the lizard. And so
16 we had to send our inspector out to educate them.
17 And they were rather resistant to the idea that they
18 were supposed to, like, glove their hands or
19 something like that, to, to take the x-rays of the
20 animals.

21 JAMES FUTCH: I'm sorry. Did that come up
22 in -- the taking of your pictures, it seems there
23 was an awful lot of completely unshielded hands in a
24 great many positions, too, depending upon the size
25 and shape and position.

1 DEBBIE GILLEY: You do not have to wear gloves
2 unless you're in the primary beam. That was the
3 whole purpose. The photo that I showed you has the
4 hand in the primary beam. That person got a
5 radiation dose from that. When you're outside of
6 it, you may get some radiation if you're out of the
7 primary beam because of scatter, but you're not
8 going to get the level of radiation that you
9 normally get if you're in the primary beam.

10 JAMES FUTCH: When you were talking about
11 regulatory guidance for this situation, it triggered
12 a memory in my head, because I sit on the IEE
13 committee that sets the radio frequency standards
14 that's used for the FCR for cell phones and stuff
15 like that. And that standard's been around since
16 military radar in the 1960s, which is where it
17 started in IEE standard. Only in the past probably
18 three years, has have some of the experts said, you
19 know, we ought to think about a standard, at least
20 look at exposures for animals. And so that's,
21 that's kind of something that -- they're having a
22 fair bit of resistance from folks who don't think we
23 need to worry about things like that.

24 DEBBIE GILLEY: So the veterinarians constantly
25 reminded me that their relationship is with the pet

1 owner. And there is no constraint for exposure to
2 the animal. I mean, you know it's like Kathleen
3 Peremans doing whole body CTs of race horses. I
4 mean, she's, you know, she's pretty much given a
5 tremendous amount of dose to that horse. But that
6 is not the concern. The concern is she's meeting
7 the needs of the person that owns the horse.

8 This is really hard for the pet-loving
9 community. What we did when it comes to
10 optimization is, we just said in the, the thing is
11 if you optimize for giving a low-dose exposure that
12 you can see the, the information that the physician
13 needs to see, you are reducing the dose to the
14 worker. That's how we managed optimization.

15 So if you columnate and you use high kV, low mA
16 settings, you're giving less radiation to that
17 person that's having to hold that animal. Even
18 though they're wearing the lead, even though they
19 are wearing the lead aprons and many of them wear
20 the thyroid shields and ISOL. At University of
21 Vienna, they wear lead impregnated glasses. They
22 are decked out. They, they, they look sharp when
23 they just do basic x-rays.

24 But you won't see that in other countries.
25 You'll see them wearing nothing. They are lead

1 gloves there. In fact, I have a picture of one of
2 the veterinarians, she's a specialist in bovines, so
3 all she does is cows. And so she came out and
4 showed us how they did a -- I can't remember what
5 it's called. It's not a knee, but it's the joint in
6 the cow, but they're not knees. They're called
7 something else. And she was x-raying and she
8 actually used the extended arm to hold the plate,
9 the detector, to keep herself from getting that.
10 And she x-rays, you know, sometimes she x-rays
11 twenty cows a week. Because they bring them in
12 there or she goes out to the, to the farms to look
13 at certain problems with cows.

14 So she potentially, if you look at the number
15 of procedures she does, if she doesn't use radiation
16 protection, she could get a significant amount of
17 radiation.

18 RANDY SCHENKMAN: Sure.

19 KENNETH BARNHART: I have a question. I do
20 inspections a lot. I work for Jorge. You talked
21 about industrial versus medical. The way that some
22 of our veterinarians are registered. Why aren't
23 they all industrial?

24 CLARK ELDREDGE: It was their choice.

25 KENNETH BARNHART: Why did you allow them the

1 choice?

2 CLARK ELDREDGE: Why not? Is there any reason?
3 I mean, animals aren't people, right? So they have
4 the -- they, they can be registered, but I guess
5 it's their marketing. It's their, whatever, that
6 they're demonstrating to their -- the owners of the
7 animals that they are meeting a higher standard.

8 KENNETH BARNHART: But they aren't x-raying
9 human patients. Why would they be held to human
10 standards?

11 DEBBIE GILLEY: The point comes to what does
12 the State of Florida regulations say about medical
13 exposure? Does it say medical exposure is only doe
14 humans? Is patient considered only a human? And
15 that's what the BSS says.

16 The BSS says, medical exposure's a planned
17 exposure to a human being. So we could not
18 piggyback on to the medical guide for veterinarian
19 because of that specifically stated in the BSS.

20 KENNETH BARNHART: Like on a, the material
21 side, they're strictly treated as industrial,
22 essentially. They don't -- if they want to use a
23 human standard, say, for a therapy machine, they
24 take a human standard and they take away the things
25 that are there to protect the patient. That's how a

1 veterinary license is written. So that's easy for
2 me to see. I just, on the x-ray side, I didn't
3 realize there was some -- because all the ones I've
4 inspected have been industrial. I never saw any
5 that had the medical part of it. I thought it was
6 kind of interesting you combine the two.

7 DEBBIE GILLEY: Isn't it a lot less expensive
8 to get an industrial x-ray than --

9 CLARK ELDREDGE: A hundred bucks difference.

10 DEBBIE GILLEY: Is that all?

11 CLARK ELDREDGE: This is Florida.

12 KENNETH BARNHART: Materials side is really --

13 JAMES FUTCH: Take away some decimal places,
14 Debbie. Right over here.

15 CLARK ELDREDGE: Even us to other states, take
16 a couple decimal points with accelerator licensing.

17 DEBBIE GILLEY: Adam, does University of South
18 Florida have a veterinary university?

19 ADAM WEAVER: Not really, no. We don't --

20 DEBBIE GILLEY: University of Florida is
21 where --

22 ADAM WEAVER: We have vivariums all over the
23 place, but they're small animals.

24 DEBBIE GILLEY: University of Florida has a
25 pretty elaborate veterinary university.

1 ADAM WEAVER: There's not many in the state.

2 MARK SEDDON: We do imaging for a lot of -- we
3 do all the imaging for SeaWorld, Animal Kingdom and
4 Disney. So we have gorillas and dolphins and all
5 kinds of stuff.

6 DEBBIE GILLEY: You bring them into the
7 hospital?

8 MARK SEDDON: They come into Celebration. They
9 shut down the department.

10 DEBBIE GILLEY: Oh, my goodness. I didn't know
11 that.

12 MARK SEDDON: Yeah. Well, it threw me off
13 because we do dose assessment for all our CTs. I
14 was flagging, like, ten times higher doses. Ten
15 time higher doses. What's this patient Gorilla? I
16 thought it was somebody's last name Gorilla. I
17 finally realized it's literally a gorilla.

18 DEBBIE GILLEY: I would love to see photos.
19 Invite me down when you do it again because I really
20 started to collect quite a library of very
21 interesting photos of animals being done.

22 The one, the first one I had of the electron
23 therapy for the lion came from South Africa. And
24 somebody knew that I was working on this project,
25 and they sent me, I don't know, 25 or 30 pictures of

1 this lion getting, you know -- South Africa as
2 limited access to radiation therapy for people and
3 here we are doing a lion. And they did do it in a
4 radiation therapy facility that's used for humans.
5 They don't have a dedicated stand alone, so --

6 RANDY SCHENKMAN: Kathy, you had a question?

7 KATHLEEN DROTAR: No. We actually treated a
8 dog for a sarcoma of the mouth after hours, like you
9 said. And the veterinarian came with, with the dog
10 and anesthetized the dog on the table and kept him
11 quiet while we were doing all the planning. But
12 we -- I had, just before that, I found out -- I read
13 an article that was from University of Pennsylvania,
14 about how they treated one of the animals. So that
15 was sort of how we got the dosage. But I think he
16 came in three times. And it was like, after like,
17 two weeks, he came back in. But you could actually
18 see the tumor melt after the treatment. He was very
19 responsive. He lived for about another year.

20 But the other thing that was of concern is that
21 the vet techs, themselves, and I've had several
22 students who were vet techs that came into my
23 program. And when you talk to them about, about
24 protection, what their, their training was mostly
25 about how to hold the animal for, for the x-ray that

1 they were doing, as opposed to whatever, you know,
2 do you have an apron? Some did, some didn't. What
3 about your badge? Maybe, maybe not.

4 So there's a -- you know, because they're
5 animals, I guess.

6 DEBBIE GILLEY: They don't seem to have the
7 same level of radiation -- I think it's a training
8 issue. I don't think they know there's a danger of
9 potential harm.

10 CLARK ELDREDGE: They're required to have --
11 they're not allowed to be exposed to scatter without
12 the lead going through the shielding. So we have
13 a -- so in Florida, they are required to wear
14 aprons. They're required to wear badges. So if
15 many people coming into your training don't know
16 that, then that's --

17 KATHLEEN DROTAR: Well, they do when they
18 leave.

19 CLARK ELDREDGE: We like them to know when they
20 came in.

21 JOSEPH DANEK: Nuclear power plants, same,
22 nuclear power plants in the State of Florida. We
23 have a portable radiation, portable radiation
24 detectors, and workers, prior to entering the plant,
25 have to go through this radiation monitor. At least

1 on one occasion, probably several occasions, the
2 workers come in and they set off the alarm; can't
3 get in. What's going on?

4 It turned out that, it turned out their cat
5 they left sleep in bed with them after it got
6 exposed to Iodine-131.

7 DEBBIE GILLEY: Yeah.

8 JOSEPH DANEK: Got contaminated with it.

9 DEBBIE GILLEY: I don't know how many people
10 were around after 9-11, we started putting radiation
11 detection monitors in all of our airports. And one
12 of the things that came out of Florida was, we were
13 actually at places in Ocala, I think. We were
14 actually bringing cats in and doing Iodine-131
15 procedures on them; putting them back in their cage
16 and shipping them back to California.

17 Well, one got caught because the alarms went
18 off. We didn't know. The State of New York was
19 very angry at Florida at the time because they had
20 really strict rules about this and we were kind of
21 lackadaisical. We changed it after it happened. We
22 just simply didn't know that was happening until
23 they put these radiation detectors into the airports
24 to catch it. So people were not following the
25 instructions. The cats weren't staying three days

1 in the facility before they were shipping them off.

2 Do you remember that? Do you remember that?

3 You weren't around. It was a long time ago.

4 JAMES FUTCH: Vaguely. Something about cats.

5 That's about it.

6 DEBBIE GILLEY: I think -- I was working in the
7 materials program at the time and it came to us
8 because we had issued the license for the
9 veterinarian to do that. Did not realize that they
10 were shipping them off without -- with them being
11 radioactive enough to be detected by these monitors.
12 But it doesn't take much to be detected by these
13 monitors.

14 ADAM WEAVER: They're very low levels.

15 DEBBIE GILLEY: Very low levels, yeah.

16 RANDY SCHENKMAN: Anybody else have any
17 questions?

18 ADAM WEAVER: Very interesting.

19 RANDY SCHENKMAN: No? Thank you so much. That
20 was fascinating.

21 (Applause).

22 RANDY SCHENKMAN: Okay, Clark. Okay. We're
23 going to take a five-minute break, okay?

24 (Proceedings Recessed at 11:01 a.m.)

25 (proceedings Resumed at 11:19 a.m.)

1 RANDY SCHENKMAN: We're going to start back up
2 again.

3 James?

4 JAMES FUTCH: So we, we have kind of a
5 follow-up series of information questions that
6 dovetails into your talk that we wanted to address.
7 Not looking for any, necessarily recommendations,
8 you know, written down, stuff like that, but Clark
9 wanted to get a little bit of a discussion.

10 So this is a website from a company that has a
11 veterinary system and Clark and Camilla know a
12 little bit more about it. If you guys want to sum
13 it up.

14 CLARK ELDREDGE: So this is a company that has
15 basically, they're coming up with a -- marketing a
16 3D tomosynthesis x-ray system. But, yeah, much like
17 breast tomo. Taking a head that sweeps, taking
18 multiple images. They can focus it. You can slide
19 through it in layers; look down it.

20 It's a machine that runs 30 to 45 seconds and
21 our code requires that dead man switches are on
22 x-ray machines. This is so that if for something
23 that does happen when the head's on, that when you
24 pick your finger off the button, the machine stops.
25 If there's something comes up that you have to go

1 and help the patient or, you know, get in there,
2 some of the exposure stops.

3 They've requested to be released from that
4 standard because the software -- they're talking
5 about how the software auto terminates after the 45
6 seconds of imaging. But, you know, as I say, the
7 purpose in our radiation protection is that that's,
8 you know, if something happens, the animal slips,
9 who knows what could go on with the thing that
10 they're going to have to go in there and interrupt,
11 that's the purpose of removing your finger stop so
12 you can go in and address whatever the emergency
13 that's happening or the situation that makes you
14 want to interrupt the process that cuts off the
15 machine.

16 JORGE LAGUNA: They're unable to terminate the
17 program through the computer?

18 CLARK ELDREDGE: Well, which is faster? Having
19 to go into the system and hit a stop button or being
20 able, you're holding a switch down and you just take
21 your hand off.

22 CHANTEL CORBETT: Why did they want the switch
23 gone?

24 CAMILLA GUY: They're saying it presents a
25 disadvantage. It presents unnecessary repeated

1 examinations overall for the veterinarians.

2 CHANTEL CORBETT: They're planning on dropping
3 their control randomly? That doesn't make sense.

4 RANDY SCHENKMAN: I mean if they don't take
5 their finger off the button, after --

6 CLARK ELDREDGE: It automatically terminates
7 when the system is finished at 45 seconds, so --

8 CHANTEL CORBETT: Right.

9 RANDY SCHENKMAN: So can't they adjust the
10 system? Instead of -- so that it goes longer but
11 you can take, still take your finger off and stop
12 it?

13 CHANTEL CORBETT: They're saying they don't
14 need the button.

15 CLARK ELDREDGE: They don't want to have the
16 dead man switch on it at all. They want you to push
17 the button, walk away and let the system do its
18 45-second exposure and then you go in and finish it.
19 Because otherwise, on our standards, once you pull
20 your finger off, you pull it off at 20 seconds, it
21 stops. And they're afraid that people are not going
22 to want to hold the button that long, but --

23 JORGE LAGUNA: It could be like a terminator.
24 As soon as -- if they have to press it again, it
25 will stop it. At 15 seconds or 10 seconds.

1 CHANTEL CORBETT: Just an e-stop button versus
2 a dead man switch.

3 JORGE LAGUNA: Yeah. Let it run 25 seconds or
4 whatever.

5 ADAM WEAVER: Like a motion switch?

6 CHANTEL CORBETT: Yeah. Like, you know, the
7 nuclear cameras, like a movement, you know, e-stop
8 button. Maybe that's an option versus the dead man
9 switch or --

10 DEBBIE GILLEY: I think they call that a photon
11 barrier.

12 CHANTEL CORBETT: A button that they could hit
13 to stop that exposure.

14 DEBBIE GILLEY: Architecturally, they could add
15 a motion detector that cuts it off. I'm kind of
16 confused, though. Are they not staying in the room?

17 ADAM WEAVER: Isn't this a desktop unit, too?
18 It's not that big, is it?

19 CHANTEL CORBETT: No, it's not. It's a smaller
20 model.

21 CLARK ELDREDGE: Yeah. This appears to be a
22 small model. I mean it is a low kV device. It's
23 70kV, 140 micrograms for pulse, 50 milliseconds
24 pulse link, 45 pulses for the entire sequence.

25 KENNETH BARNHART: This is purely for

1 veterinary?

2 CAMILLA GUY: Yes.

3 KENNETH BARNHART: Under part 7, it doesn't
4 have to have a dead man switch.

5 CHANTEL CORBETT: You said it falls under which
6 part, I'm sorry?

7 KENNETH BARNHART: Part 7. It doesn't have to
8 have a dead man switch.

9 CLARK ELDREDGE: Anyway, well, they read our
10 rules and asked us to be -- whatever.

11 ADAM WEAVER: So they're trying -- they're
12 going to use it for human use, too, or something?

13 CLARK ELDREDGE: Anyway.

14 ADAM WEAVER: Is there a change on the top of
15 the --

16 JAMES FUTCH: I'm looking for it. There it is.

17 ADAM WEAVER: There it is.

18 CLARK ELDREDGE: There it is.

19 CHANTEL CORBETT: And you said 15 by 11
20 centimeters --

21 JAMES FUTCH: That's a snake on the left, I
22 think.

23 DEBBIE GILLEY: They didn't know what the
24 images were. Is that the head of the snake?

25 JAMES FUTCH: Some of them I wasn't sure.

1 CLARK ELDREDGE: Anyway, that's a little oddity
2 of what we deal with on a going day, people coming
3 in and requesting things like this.

4 DEBBIE GILLEY: So they must have no FDA
5 approval for veterinary.

6 CLARK ELDREDGE: Right. The FDA doesn't have
7 any.

8 DEBBIE GILLEY: Doesn't care.

9 CLARK ELDREDGE: Doesn't care.

10 DEBBIE GILLEY: Then you need to go back to IEC
11 standards and see what IEC says. That's a pain in
12 the butt.

13 CLARK ELDREDGE: I would gather there's not
14 that -- since this is an international company. And
15 they're bound to be making it to IEC standards.

16 DEBBIE GILLEY: Yeah, and does it have CE
17 marking out of Europe?

18 CLARK ELDREDGE: I haven't seen anything about
19 that. This is an e-mail that came in a couple days
20 ago and we just started reviewing it, so --

21 ADAM WEAVER: Wouldn't all their standards or
22 specs be at the bottom?

23 DEBBIE GILLEY: That's a -- that's an
24 advertising thing there. Really not the --

25 ADAM WEAVER: Yeah.

1 CAMILLA GUY: I have the user guide. I sent
2 you the user guide as well.

3 JAMES FUTCH: This is interesting. They've got
4 veterinary as a category. Separate from --

5 CHANTEL CORBETT: Separate from orthopedics.

6 CLARK ELDREDGE: Orthopedic.

7 JAMES FUTCH: Okay. Now we got people. This
8 looks a little different.

9 RANDY SCHENKMAN: That's a different machine.

10 JAMES FUTCH: Yeah. Maybe the same software
11 but different machine.

12 ADAM WEAVER: Oh, yeah. It's different
13 machines.

14 KENNETH BARNHART: Is it still the same
15 machine?

16 JAMES FUTCH: It's got to be in this case.

17 DEBBIE GILLEY: Well, I guess you should look
18 and see if the dental looks like if it has a dead
19 man switch. I think it's required by FDA.

20 CHANTEL CORBETT: Are they just seeking
21 approval for the veterinary unit or are they
22 seeking --

23 CLARK ELDREDGE: Just the veterinary unit.

24 Okay. Should I go on?

25 JAMES FUTCH: We can. So we have -- with your

1 permission, Madam Chair.

2 RANDY SCHENKMAN: Absolutely.

3 JAMES FUTCH: We're going to move to -- it says
4 Clark Eldredge, radiation machine update. Let me,
5 if you don't mind.

6 CLARK ELDREDGE: Yeah, go ahead.

7 JAMES FUTCH: So for a really long time, the
8 Bureau of Radiation Control has been sending out
9 paper rules for 20,000 or so x-ray facilities at
10 current --

11 CLARK ELDREDGE: I wanted to put this at the
12 end.

13 JAMES FUTCH: Sorry. You go.

14 CLARK ELDREDGE: I go. Okay. We are
15 communicating so well today. Okay.

16 ADAM WEAVER: I just got my renewal today.

17 CLARK ELDREDGE: So starting the radiation
18 program update. We have crossed 20,000 registrants
19 total for the state. Dental's, of course, 41
20 percent at 8400. Medical, when you consider the
21 cross cutting of medical being MD, hospitals,
22 diagnostic centers, interventional practices; things
23 like that, that's 28 -- 29 percent, 5900
24 registrants.

25 As I mentioned earlier, veterinary are about

1 ten percent, 2100 registrants. Chiropractic's next
2 on the list at 1500. Then industrial, 1100.
3 Podiatric, 6300. Therapy, 53 -- excuse me, 630 is
4 podiatric. Don't add an extra order of magnitude
5 there. That's the wrong thing to do.

6 Therapy is 530, but that's both -- that is all
7 therapy associated registrations, accelerators and
8 the associated treatment planning and simulation
9 registrations.

10 Educational's around 200 and industrial
11 accelerators are 23. And of those are the --
12 includes those veterinary ones I mentioned earlier.

13 We've got Honeywell has one here, they do in
14 the area, they do space research with. We've got
15 somewhere in the state, I think they've got an ion
16 implanter still, so that's part of that.

17 We've got the cyclo -- the UF, FSU accelerator
18 in that list. So the research accelerators.

19 So for personnel, we actually have -- our
20 registration staff positions are all filled at the
21 moment. Last year, we had someone depart in July
22 and the new hire started right about now at the
23 beginning so they weren't that useful during the
24 renewal period, which we just started. We're hoping
25 nobody leaves in the next two weeks or month, but

1 you never know.

2 Our environmental program consultant position's
3 currently open. We had three qualified applicants,
4 including a neurologist and a dental surgeon apply
5 for it. I don't know what they were --

6 ADAM WEAVER: They must not have looked at the
7 salary.

8 CLARK ELDREDGE: So at this point, we'll --
9 introduce Miss Camilla Guy, who is our new medical
10 event investigator and enforcement coordinator.
11 You're from FAMU. Got your Master's in public
12 health there. Where did you get your chemistry
13 degree from?

14 CAMILLA GUY: FAMU as well.

15 CLARK ELDREDGE: FAMU as well. So you're a grad
16 of chemistry. We're quite fortunate she chose to
17 come work with us.

18 She was an intern with us and did excellent
19 work during her internship.

20 CAMILLA GUY: Thank you.

21 CLARK ELDREDGE: And can you give us an update
22 on medical events.

23 CAMILLA GUY: I did receive one recent medical
24 event from Florida East Coast on electronic
25 treatment --

1 CLARK ELDREDGE: We don't mention names.

2 CAMILLA GUY: Sorry. Sorry about that.

3 ADAM WEAVER: No names.

4 CAMILLA GUY: Well, it was an electron
5 treatment to the scalp. The site was correct, but
6 the issue was the dose. They used 6 mev instead of
7 9 mev. Don't know yet of where the miscalculation
8 had went. So instead of receiving a total dose of
9 6,125, the person received 6,094. So it was
10 slightly underdosed by 91 -- I mean 31. Sorry about
11 that.

12 So I followed up with them and we need to
13 receive a report by the end of the week and I'll
14 know more from there.

15 CLARK ELDREDGE: Now, for -- as I mentioned,
16 renewal period's just started. As always, we have
17 fun. We got a new contractor this year. And every
18 time we have a new contractor, it's a learning curve
19 for them. Hopefully, the invoices will be mailed
20 this week. We actually are -- \$2,900,000 is what
21 we've billed, so we're approaching the \$3 million
22 mark. But we're actually now moving very slowly and
23 graciously to taking electronic payments. So this
24 first step in moving forward is what James was
25 starting to talk about.

1 JAMES FUTCH: So one of the things under my
2 section is the IT functions for the Bureau of
3 Radiation Control. And we started a project,
4 literally two years ago, to take electronic
5 payments, credit card payments online. Right at the
6 moment we're doing, what is it, 20,000 facilities
7 and roughly 20,000 paper checks coming in with, with
8 all that entails for the next couple months.

9 So right about the time we started this, we
10 started working with one state contractor and then
11 the contract changed. And they put a hold on all
12 new projects while they tried to convert from Bank
13 of America as the state contractor taking electronic
14 payments to the new group, which is NIC, N-I-C. And
15 so we picked that back up again when they were ready
16 to and have moved forward in the process.

17 So what we have to show you today is a piece of
18 what's going to be in place hopefully in some
19 fashion for the second notices by the end of this
20 year. So by the time we come back in in May, that
21 should be fairly, fairly well along in terms of
22 those. And so you might consider this to be a soft
23 roll out of, of something that's taken a long time
24 to pull together.

25 So to build an electronic payment system, the

1 first thing you have to do is set up our side of it
2 so that people have a way to get to a site online; a
3 way to locate their individual invoice in this case
4 and print it out if they didn't get the one in the
5 mail.

6 And then the back end, which is the part that's
7 still to come is, when you transfer it off to the
8 intermediate vendor with the token and they get the
9 payment come back with it. So that's, that's in
10 development. Hopefully we'll be ready around the
11 beginning of December, which is the current, go live
12 date for that part of the project.

13 Do you want to show them the rest?

14 CLARK ELDREDGE: Yeah. At this point, anybody
15 who wants to, can go get a copy of their invoice.
16 The invoices have been run. They're online right
17 now. But, you know, so you can see that. In fact,
18 it's a good thing since we normally would've mailed
19 out, had the invoices mailed out two weeks ago. And
20 with the new contractor coming online.

21 So we have three links, three of our landing
22 pages -- two of our landing pages and our documents
23 page have the link to the invoice system. The name
24 of the link is pretty straightforward:
25 xray.floridahealth.gov. That was actually -- it was

1 the first thing you think of, but we were trying to
2 make it more generic and more -- total covering
3 radiation machines, but everything we tried to think
4 up for another name was a lot more complicated; a
5 lot more typing, so we defaulted back to x-ray even
6 though we're not just x-ray.

7 JAMES FUTCH: And this is the current home page
8 for the x-ray machine program. We've got the same
9 first sentence, first couple sentences on the home
10 page of the Bureau, itself. And if we follow the
11 link, you're going to need a couple things.

12 We actually modeled this after, for those of
13 you who check licenses for health care professionals
14 in Florida, the part of the department that runs
15 that has adopted -- whoops, you can't see it. Hold
16 on -- has adopted this color scheme. And it's
17 actually, it's actually not blue. It's actually
18 cyan or teal, I guess is what it is. But it looks
19 like the MqA license verification mechanism. So
20 that's the overall color scheme.

21 And in order to look somebody up, you actually
22 have to know -- and this, again, initial version,
23 soft roll out. Trying to be protective of
24 information and the way bots work out there. So
25 this is the mechanism by which you go and look up

1 your information.

2 So you have to know two things. You have to
3 know the JR number of the facility and you have to
4 know the facility location zip. If you do that --
5 do you know which one you want to use, Clark?

6 CLARK ELDREDGE: No. Let's start with the big
7 one. You want me to pull up? You got it?

8 JAMES FUTCH: Yeah.

9 CLARK ELDREDGE: We texted back and forth last
10 night. We pulled it up on our phones.

11 JAMES FUTCH: Now, live system, first time use,
12 all council here, I'm betting this isn't going to
13 work, just to kind of lower expectations.

14 But it actually did. What do you know?

15 CLARK ELDREDGE: Anybody recognize this
16 facility?

17 MARK SEDDON: Hey, great. I just actually
18 texted my program manager to pull these up now
19 because we were asking about it the other day.

20 JAMES FUTCH: So this is the home page, I
21 guess, if you will, of the facility information,
22 once you pick your JR number and the zip code that
23 goes with it. There's not, at the moment, any kind
24 of authentication. I'm not sure there ever will be.
25 But this is, this is what kind of passes for

1 authentication at this point. You've got to know
2 the JR number and you have to know the zip code that
3 goes with that facility, which we figure most of you
4 probably know those two pieces of information if
5 you're trying to pay your renewal invoice.

6 I guess the next thing to take a look at is,
7 this is what the renewal invoice looks like, or at
8 least this is the template for what you're seeing
9 online. The top half of the page. And we've added
10 a little bit of wording in here to kind of make it
11 work with the rest of the website.

12 I don't really look at these very often. I
13 don't do 20,000 mail openings and check deposits
14 like the rest of the x-ray staff does. So, so it's,
15 you know, this is, this should look familiar to
16 those of you who do.

17 CLARK ELDREDGE: Now, this will be frozen at
18 the invoice for the renewal at this time.

19 JAMES FUTCH: And it says that, right?

20 CLARK ELDREDGE: Right. Actually, we've got
21 that little notice there. We also have notices
22 saying, you know, make sure you're not going to pay
23 twice. Because we will, you know, don't -- we will
24 deposit whichever checks gets to us first. The
25 other will be sent back, that type, you know.

1 MARK SEDDON: Is the inventory listed up there?
2 I'm sorry.

3 CLARK ELDREDGE: Lets go back.

4 JAMES FUTCH: I'm going to remote control. I'm
5 also trying to see this. So if we go back -- and
6 there's a couple other buttons here. So what you're
7 looking at is the tab that comes up by default,
8 which gives the facility information.

9 So if you want to look at machines, machines
10 are here (indicating). It defaults to ten at a
11 time. You can pick 175, which I think is more than
12 any facility, and then scroll down the page and see
13 all the machines, the JM numbers, the status, the
14 serial numbers over here. The make, model and
15 actually the last column, Ken, I think, what do we
16 call this? This is location? Where you find it?

17 KENNETH BARNHART: Yeah.

18 CLARK ELDREDGE: What room it's supposed to be.

19 KENNETH BARNHART: Where it's supposed to be.

20 JAMES FUTCH: I'll make it a little bit bigger
21 so you can see. And we're springing this on the
22 inspection force, too, so you're the first person to
23 see it.

24 KENNETH BARNHART: Thanks.

25 JAMES FUTCH: Be gentle. Please be gentle.

1 JORGE LAGUNA: We'll have the registrants being
2 notified that this is going to happen?

3 JAMES FUTCH: It's on the website.

4 CLARK ELDREDGE: It's on the website. That's
5 how they're being notified.

6 JORGE LAGUNA: They have been receiving letters
7 for years and years.

8 CLARK ELDREDGE: Right. They will continue to
9 get letters. And right now, when you call into the
10 phone number, it should -- one of the options for,
11 you know, if you call in our main number and say, I
12 want to renew, it will have a statement, you can go
13 to the website to get a copy of your invoice.

14 And so that will be -- as well as our automated
15 response on our e-mail. We have the generic public
16 e-mail address, radiationmachine@fll.gov. We
17 haven't gotten the response updated yet since it's
18 not controlled by us. We have to go through the
19 department to get that updated, but we'll get that
20 one so the automated response also has a link to
21 this.

22 JAMES FUTCH: So another thing about this
23 particular screen is, we have been doing this for
24 how many decades? Registrations of machines and
25 renewals. And we're not listing the deletes, we're

1 not listing the storage, either?

2 CLARK ELDREDGE: Storage is in there. They get
3 to pay for storage, so they're in the list.

4 JAMES FUTCH: So this is the very first time
5 that the public, you all, will see the actual data
6 that actual humans who have passed from this earth
7 or been here for a very long time, have put in this
8 database over decades. You know what that means?
9 There's some funky data in this. We just haven't
10 found it yet. So if you run across it when you're
11 looking at this for very first time, please let the
12 x-ray program know.

13 CLARK ELDREDGE: And don't be mean to us.

14 MARK SEDDON: You guys have been sending out
15 the inventories for years.

16 CLARK ELDREDGE: Yeah, the inventory is
17 attached to the bill.

18 MARK SEDDON: And everyone is supposed to be
19 checking that to confirm.

20 CLARK ELDREDGE: That's very true.

21 MARK SEDDON: There's always hiccups.

22 CHANTEL CORBETT: But in that case, like if
23 you're going to pay online, is there a way to do
24 your new changes on here or if you have changes, do
25 you still have to go paper?

1 CLARK ELDREDGE: Right now, changes are still
2 paper. You're talking about Version 3. Version
3 1 --

4 CHANTEL CORBETT: You should do the change,
5 like if you're making deletions, obviously, your fee
6 is going to be different.

7 CLARK ELDREDGE: Right. So then you have to
8 send in the 1107 with it. And that comment's in
9 there.

10 CHANTEL CORBETT: Okay.

11 CLARK ELDREDGE: So Version .5, .9, something
12 like that, is here's the invoice. Version 1 is you
13 can pay the renewal one at a time. So if you're a
14 large company that's got, a large organization that
15 has a hundred facilities, somebody has got to go
16 there one at a time for all hundred facilities. And
17 no authentication.

18 Somewhere, Version 2 or 3, we'll eventually
19 move through some of our authentication system where
20 people would be able to put together an account and
21 link all their facilities into a single ACH payment
22 to cover multiple cities, but that's a little
23 farther down the road, and --

24 JAMES FUTCH: We're racking our brains. And
25 our financial, fiscal folks are wrapping their

1 brains around making very sure when payments start
2 coming in for just this one purpose, we can actually
3 retrieve them and put them in the correct place. At
4 leave give you all credit in the correct place. You
5 can always take money, but --

6 CHANTEL CORBETT: I don't think they should
7 charge for extra authentication if they want to pay
8 their bill.

9 JAMES FUTCH: Yeah. This is the fees tab.
10 Fees due tab.

11 MARK SEDDON: Yeah. All right.

12 CLARK ELDREDGE: If you will notice on this
13 fees, too, there's the registration and somebody
14 just registered three new tubes in the last couple
15 days since the --

16 MARK SEDDON: Right.

17 CLARK ELDREDGE: So those are the added to
18 fees. Apparently, there were no deletes associated
19 with those three added tubes, or no swaps, so that's
20 why it's three -- more money. So this will not show
21 up in the renewal invoice.

22 MARK SEDDON: Right.

23 CLARK ELDREDGE: So you would have to go
24 through and -- we don't have an online, again, in
25 Version .9, probably even Version 1, we won't have

1 any online invoice for the added tubes as they're
2 added. It would just be the renewals, the annual
3 renewal would be on the online invoice.

4 KEVIN KUNDER: What happens if you hit the view
5 2023?

6 JAMES FUTCH: You really want to go there?

7 KEVIN KUNDER: Never mind.

8 CHANTEL CORBETT: We already did that.

9 KEVIN KUNDER: Okay. So that's not showing the
10 added tubes.

11 JAMES FUTCH: No added tubes.

12 JORGE LAGUNA: It's not there yet.

13 CHANTEL CORBETT: The reason I asked about the
14 changes is because it has the blanks next to the
15 money down there.

16 CLARK ELDREDGE: No, you can print this off and
17 mark this up and send it with your 1107. This
18 allows for that as well.

19 JAMES FUTCH: Okay. Anybody want to see any
20 other facilities?

21 CLARK ELDREDGE: Let's do the small one.

22 JAMES FUTCH: Okay.

23 KENNETH BARNHART: I need you to find me, too.

24 RANDY SCHENKMAN: But if you have the added
25 fees on that, that last sheet, under the fees, do

1 they have to pay that now or do they have to pay
2 that for next year?

3 CLARK ELDREDGE: On the renewal invoice, there
4 will be -- there are additional -- you will be
5 invoiced for the -- on the fees due tab, you will be
6 invoiced for all those fees that are on there.
7 You'll be getting a bill for it.

8 On the renewal invoice, itself, the added fees,
9 there are ones you didn't pay previously you should
10 have already paid is usually what those are. People
11 who are billed an added tube back in April and they
12 never paid it, it shows up as an overdue fee under
13 those additional fees. Or for folks who didn't
14 register for two or three years until they finally
15 realized they had to register for the state or were
16 caught and owe us for several years, that shows up
17 there.

18 JAMES FUTCH: So we've got -- we went from the
19 large facility to the small. This should be
20 familiar with Dr. Rodriguez. And here's the
21 machines. One. Hopefully that's correct.

22 LUIS RODRIGUEZ: Yes.

23 (Laughter)

24 JAMES FUTCH: So this is just the, the annual
25 fee, so it should match what's over here. You got

1 \$47 on this one.

2 MARK SEDDON: So I notice the dates are a
3 little different. Is there like a standardized date
4 when the cut off is or is it based upon -- like this
5 was 9-14 and the other facility was 9-7.

6 CHANTEL CORBETT: No, that's 9-7.

7 MARK SEDDON: It said 9-7 too? Okay. I'm
8 sorry.

9 CLARK ELDREDGE: So the other tab fees due will
10 be updated as time goes on.

11 JAMES FUTCH: Yeah, you did see 9-14. It's
12 back over here. It's right here (indicating).

13 MARK SEDDON: Yeah.

14 JAMES FUTCH: So this, as the people pay, what
15 will happen is, so this fee is due. So let's say
16 Barry decides to pay their fee by sending a check
17 today. It gets processed. When that runs through
18 the whole system and we update the data that's
19 running this website, which eventually will be
20 nightly, then it will tell you what the date is
21 right here (indicating).

22 MARK SEDDON: Okay.

23 JAMES FUTCH: Then when you come to fees due,
24 it will actually say no fees due.

25 MARK SEDDON: Great.

1 CHANTEL CORBETT: So when is the payment button
2 going to be live?

3 JAMES FUTCH: December.

4 CLARK ELDREDGE: Yeah, December. It will be
5 hopefully with the mail out of second notices.

6 JAMES FUTCH: Still, still limited uses for
7 this purpose.

8 CLARK ELDREDGE: We have about ten percent of
9 the people who don't send their checks in on time.
10 And those are the ones in that, you know, that is so
11 our initial try of getting this all straight will
12 only be for about 2,000 folks rather than 20,000
13 folks.

14 When we were looking at our sister organization
15 who, you know, sister division who takes online
16 payments were showing us the tables and the
17 information they get back from the processors. And
18 one day, you know, they'll show 3,000 deposited, the
19 next day it's 15,000 renewed -- pulled back by AMEX.
20 And we're, you know -- we don't want to have to try
21 to research that large a correction right off the
22 bat. We'll try to take it in a smaller chunk as we
23 learn how to --

24 JAMES FUTCH: Should we mention the convenience
25 fee?

1 CLARK ELDREDGE: Yes. Of course, we do need
2 our full money, so for those who are paying
3 electronically, there will be the convenience fee
4 currently set at two-and-a-half percent plus 11
5 cents. Two-and-a-half percent is the swipe fee from
6 the card processors and 11 cents is what NIC Tyler,
7 the contractor, takes for running it.

8 CHANTEL CORBETT: That's for credit cards.

9 CLARK ELDREDGE: For credit card and for ACH,
10 it's like 37 cents total. Something along that.
11 Because again, it's 11 cents for NIC Tyler's
12 processing fee. And then the banking system takes
13 28 or whatever the 20 -- whatever, 23 or 24 cents,
14 whatever it is to process the ACH.

15 JAMES FUTCH: So this was a learning, a lot of
16 learning happening with the, how this works on the
17 credit card world. Talking to some of the other
18 department systems, like the folks who run the MqA
19 system and folks running the environmental health
20 permitting for all the 67 counties.

21 And basically, you're constantly adjusting on a
22 monthly or quarterly basis, that convenience fee.
23 You have one shot at the convenience fee, but the
24 cards have a variety of convenience fees or swipe
25 fees, I guess you call it. AMEX being one of the

1 highest.

2 CLARK ELDREDGE: So as people go from their
3 Chase, two percent cash back, to their whatever
4 rewards card to that rewards card, and the fees
5 they're totaling out of the vendor changes, the
6 swipe fee or the convenience fee will shift,
7 slightly change over time as whoever has got the
8 bigger market for credit card changes.

9 JAMES FUTCH: We have one convenience fee.
10 AMEX goes through and pays for \$100,000 worth of,
11 whatever. I'm being crazy. And then a whole bunch
12 of people down here paying with some lower
13 convenience fee. So we have one that will move.
14 And it will change as time goes on to basically
15 cover all of what's happening.

16 CLARK ELDREDGE: On the average. So those with
17 a cheap credit card --

18 JAMES FUTCH: We like you.

19 MARK SEDDON: Very good.

20 JAMES FUTCH: I think that's it. Any other
21 questions? Anybody?

22 RANDY SCHENKMAN: Anything else?

23 CLARK ELDREDGE: Let me see. Let me
24 doublecheck.

25 KENNETH BARNHART: Are they going to do a

1 digital 1107 eventually?

2 CLARK ELDREDGE: That's probably Version 4,
3 yeah. And that's after we get all the security and
4 authentication in place.

5 KENNETH BARNHART: Okay.

6 CLARK ELDREDGE: Because I don't think anybody
7 really wants to go pay somebody else's renewal fee.
8 So worrying about security on taking money from
9 somebody, but once somebody can go in and mess with
10 somebody else's records or do something crazy and
11 malicious, that's when you need -- obnoxious, when
12 you start to need to put security levels on it.

13 And I think that does it for us at this point.

14 JAMES FUTCH: Did somebody say lunchtime?

15 RANDY SCHENKMAN: Everybody ready for lunch?

16 BRENDA ANDREWS: Ready. They're waiting on us.

17 RANDY SCHENKMAN: Okay.

18 JAMES FUTCH: What time do we have to come
19 back?

20 RANDY SCHENKMAN: We have to come back at 1:30.

21 CHANTEL CORBETT: Are we here for lunch or --

22 CLARK ELDREDGE: Across.

23 BRENDA ANDREWS: The normal.

24 CLARK ELDREDGE: We get to walk across the
25 parking lot for lunch.

1 JAMES FUTCH: It's exercise.

2 (Proceedings Recessed at 11:53 a.m.)

3 (Proceedings Resumed at 1:30 p.m.)

4 JAMES FUTCH: All right. So today we have, you
5 can correct me -- sorry. Go ahead.

6 RANDY SCHENKMAN: We have Hailey Kirbach, who
7 is going to talk about 4D lung imaging.

8 JAMES FUTCH: I'm sure she's going to introduce
9 herself. Let's see if I can do a halfway decent
10 job.

11 Hailey actually worked at Prisma Health from
12 2002 to 2005 as a vascular tech in South Carolina.
13 And then she worked for, from 2005 to '21, for Miss
14 Kathy at the Keiser Sarasota campus as the clinical
15 instructor and then clinical coordinator down there
16 in Newport. And then since 2021, has worked for
17 4DMedical, an Australian company, as director of
18 clinical education.

19 She holds a Bachelor's in radiologic science
20 and Master's in business and health, and a Doctorate
21 in health science.

22 Take it away, Hailey.

23 KATHLEEN DROTAR: Yes. Very well done.

24 (Applause)

25 HAILEY KIRBACH: Thank you. Thank you. I'm

1 extremely excited about this opportunity, so thank
2 you guys so much for having me and, of course, to
3 Kathy for reaching out.

4 That is a little bit about my background.
5 Definitely started out as a radiology technologist
6 and absolutely loved it. Worked in x-ray for a
7 couple years and then went in to be a vascular tech
8 and then ended up, when I moved to Florida from
9 South Carolina, but I think that was kind of, at
10 least from my experience, a major transition in
11 what, you know, interventional radiology looked
12 like. And all of sudden, I went from working at a
13 huge interventional department with five suites and
14 15 interventional -- even everything from vascular
15 docs to nephrologists to neurologists to everything
16 that's kind of related to surgery. And everything
17 here just was, you know, was very different.

18 So I saw an ad at Keiser for teaching and I was
19 absolutely terrified, but 17 years later, I was
20 there and then ended up, like I said, pursuing and
21 got my doctorate, and then from there, kind of
22 looked for some opportunities to put that into place
23 and then ended up with this company, 4DMedical. So
24 that's a little bit about my background.

25 A little bit about the company. So we are in

1 Australian-based company. Our headquarters are in
2 Melbourne, Australia. And then we also have an
3 office in LA. And we were incorporated in 2012.
4 Our CEO is Andreas Fouras and his background is he
5 is an aerospace engineer who has no medical
6 background whatsoever, but absolutely saw the
7 opportunity to use what he had learned in aerospace
8 and how wind travels, that how could we maybe
9 possibly measure what that looks like in when -- I'm
10 sorry, when your -- when the lungs, how the lungs
11 are working.

12 So we were FDA cleared in 2019. And then
13 there's also, I think we hold currently, like, 90
14 some patents between all of the different
15 technologies and different products.

16 So we've done all of our preclinical scans.
17 Still currently collecting data on clinical scans.
18 We've got both small, small animals, like a mouse
19 and ferret, to actually a large animal scanner that
20 we have in, in Brisbane in Australia. So we're
21 still conducting, you know, some of those trials, as
22 well as all of our clinical trials that we're
23 currently still also collecting data in the U.S. and
24 I'm going to talk about some of those.

25 In addition to, we are fully, you know,

1 commercialized both in the U.S. and then in
2 Australia. I said we're FDA cleared for one of our
3 products. I'm going to talk about a lot of our
4 products, but then also TGA cleared for a couple
5 products over there.

6 So I'm going to go into a lot of detail on
7 exactly how this technology works, but it's using
8 the fixed C-arms that are in interventional and in
9 the cath lab. And then how we use the CT for the
10 masking so the patient does have to have a CT.
11 Either can be retrospective or done same day as the
12 fluoro scan. And then we use our software to then
13 produce a ventilation report.

14 So, you know, my background is radiology, so it
15 was definitely, as I said, pretty significant for me
16 to learn some of, you know, the statistics in the
17 pulmonary space and that was something that I still
18 am currently working on; attend a lot of pulmonary
19 conferences that I never did before. We also go to
20 RSNA, which is big for us because I feel like we're
21 a company that's really kind of narrowing that space
22 between pulmonary and radiology.

23 But here's a few current statistics on lung
24 health. You know, you can obviously read through
25 them. I don't have to go through them. But chronic

1 respiratory disease is the third leading cause of
2 death globally, so it's a global burden. And, you
3 know, it's not just -- I mean just from, you know,
4 health, but occupational, you know, reasons as well
5 as all sorts of different, you know, environmental
6 exposures. So there's a lot. And COPD also, you
7 know, being the sixth leading cause in the U.S.

8 So as I mentioned, you know, some of the major
9 contributing factors to that: Smoking,
10 socioeconomic status, the occupational and as well
11 as environmental. And I'm going to talk about some
12 of that exposure because the burn pits is also, you
13 know, with the veterans is something that I'm going
14 to come back to here in a little bit.

15 Some of the dollars spent. It's a pretty
16 significant market when it comes to, to the amount
17 of money that is, that is spent on lung health.

18 So interesting, when you start to look at some
19 of the ways that we actually image the lungs, that
20 there are really four major tests. And as we
21 started to, you know, really dig into that, it's not
22 only just that they're Fortis, they're Fortis that
23 are pretty dated. There are technologies that have
24 been around for a hundred years that, that haven't
25 really made much progression, such as spirometry.

1 So it was something really interesting and it's also
2 interesting in a commercialization standpoint when
3 trying to enter into a market, you know, of
4 ventilation.

5 So here's just a little bit of current, you
6 know, like I was saying about the dates when they
7 first came around. The percentage of them; kind of
8 the costs. And so, with our products we are looking
9 at -- not that we're any way think we're going to
10 replace spirometry, but with functional lung
11 imaging, we want to be able to show, you know, the
12 clinicians that we can show, you know, how these
13 lungs are functioning and be able to actually show
14 that at a much more regional level versus like, you
15 know, spirometry is a global output and we know that
16 a lot of the other imaging is very static, so we're
17 trying to be able to show a dynamic report to the
18 clinicians.

19 So here's just a couple strengths and
20 weaknesses of some of our, I don't know if you call
21 them competitors, but current ways that we do look
22 at lung health and these are a couple of the
23 strengths and weaknesses. And I'm going to -- the
24 reason why the VQ scan is important is because I'm
25 going to talk about where we're kind of headed as a

1 company for some of our future products.

2 So the way that the technology works is that so
3 we use fluoroscopy imaging and a patient lies on the
4 table, you know, and then we're able -- we do five
5 different angles during the patient's tidal breath.
6 So they have one full tidal breath. During that
7 time, we then use the CT to, you know, that's sent
8 off to our platform. We use the CT for the masking,
9 and then what the software does is it's an algorithm
10 where it looks at actually creating a texture from
11 that, you know, from the voxels, from the actual
12 images, and then it tracks that over that one full
13 breath. And it does that at five different angles.
14 So once you're able to track that voxel, we see
15 exactly how far it moved, right? And this, this
16 whole entire principle is based on PIV, which is
17 particle imaging and velocimetry.

18 So from there, this is kind of I think the
19 easiest way to kind of see it. So once we're able
20 to see where those voxels are and where they've
21 moved, we put it back to a degree of how far did it
22 move. And then it's plotted on a histogram and I'll
23 show you kind of our reports. But on that
24 histogram, then we say, all right. This is
25 basically what the patient's mean specific

1 ventilation is. So we know that the mean amount of
2 tissue movement happened within this amount and then
3 everything below that fell into a certain range and
4 then everything above that.

5 So here, you can see that we then quantify that
6 to say, okay. If it's in that less, which I'm going
7 to talk much more, I guess, specifically about the
8 actual numbers, but then that area is
9 underventilated and we're going to put that to a
10 heat map, which will be red. And if it's above
11 that, then that's going to be overventilation where
12 air is no longer compensating. We're going to put
13 that to blue and that mean specific is going to be
14 green. So that's how you get the output of that.

15 So here's, basically, a couple of things that
16 we have to do. And this is a little part of my role
17 as director of clinical education. Once we have had
18 a conversation with the facility that's interested
19 in this technology, we have to go and test the
20 C-arm. So I'll go on site and I'll just, you know,
21 acquire a test image. A couple of things is that we
22 have to have a detector that's 30 by 40 so that we
23 can fit the lungs in the field of view as much as
24 possible, and then it has to be capable of doing 15
25 frames per second. That's our requirement for our

1 software as well.

2 And then it has to be able to go to at least 90
3 degrees on one side to set isocenter, and then 72 on
4 the other. Because 72 is our two oblique angles
5 that we acquire at in addition to 36. So those are
6 some of the requirements that we absolutely have to
7 know upfront.

8 Once we have determined that, we take the test
9 image. From there, then I have to make sure that I
10 check all the DICOM tags. So I look at all that
11 metadata and make sure that the resolution is
12 basically kind of what I'm checking. So I'll check
13 the pixel spacing, the bit depth; things like that.
14 And those are all requirements that are part of the
15 algorithm because it's not -- our technology is not
16 AI based. So it is a mathematical equation, complex
17 mathematical equation that requires all of those
18 tags to be present because that's how it's going to
19 run the software.

20 So once we've determined that those -- that
21 everything passes with that and then -- so I was
22 just kind of briefly saying, I have a call here
23 right after this with Philips because we really
24 work, you know, very closely with the vendors and
25 the C-arms, because I do have to have the field

1 service engineers a lot of times come in and make
2 alterations to make sure that they can get it
3 compatible with our software. Even if that's adding
4 some tags, possibly, you know, making an adjustment
5 to the frame rate. So it's a big part of our
6 collaboration.

7 So then once we do that, we basically, you
8 know, we train the technologists that they have to
9 set isocenter. So the patient is lying on the table
10 with their arms above their head and we center, you
11 know, the lungs to basically a very precise field of
12 view. There's not much wiggle room with that
13 detector, not 72 inches ID, right? So we try to get
14 them centered as perfectly as we can.

15 And then from there, they're going to go to
16 their lateral to set their -- to set isocenter at
17 the 90 degrees and then same thing. From there,
18 once the first PA is set, they cannot move the table
19 other than up or down. And then once they've
20 centered the table from there, up or down, then they
21 cannot move the table at all.

22 So because of the way we're trying to image the
23 lungs on those angles and make sure that we know
24 that we're tracking for sure the same voxel, we
25 absolutely cannot break isocenter.

1 If for some reason if the tech were to
2 accidentally bump the table or the patient were to
3 cough or sit up, anything like that, depending on
4 where you were in that acquisition, you have to
5 start all over completely. Even if you obtained
6 three different images, three different angles, you
7 have to start at the beginning.

8 So from there, we basically, like I was saying,
9 we take five different sequences and it's just
10 through one full tidal breath. So it's a very
11 patient-compliant type of exam where the patient
12 can, like I say, be lying there, arms above their
13 head. There's no breathing instructions. If
14 anything, we try to tell them close their eyes,
15 relax. Very different than a PFT where they're
16 having to, very, very, effort dependent. It also
17 requires, you know, them to do a lot of different
18 breathing maneuvers.

19 So then we do it at those five angles. And
20 then we start where, just to make sure we capture
21 that full breath, we start at mid expiration. As
22 soon as they see the patient then getting ready to
23 take that breath, they do one full breath, you know,
24 full exhale. Then when the next breath starts
25 again, then they can stop the acquisition.

1 And this is just kind of, you know, what we,
2 what we're training them on making sure that the
3 patient's tidal breathing.

4 So a couple of things. Obviously, this is just
5 kind of what the images look like. These are not
6 obviously live fluoros. But it's a very, very
7 simple protocol. It's just one of those, it's very
8 particular, you know, with the tech that we make
9 sure that they have to have centered and set
10 isocenter and not break that and then capture that
11 full breath.

12 The way our software also works is if the
13 breath is clipped in any way, it won't run properly
14 So very important.

15 So a couple of things. That it is very,
16 obviously, non-invasive. No contrast is needed and
17 it's very low dose. We're coming out with readings
18 like around .2 millisieverts for all five, for all
19 five views, including capturing isocenter.

20 So a little bit about, you know, basically kind
21 of -- the input is the fluoro and then the CT. The
22 CT can be retrospective. It can be -- we kind of
23 say 18 months, but it doesn't really, really matter
24 as long as there's not been a major structural
25 change. So as long as the patient hasn't undergone

1 any type of surgery or made a disease process, to
2 make sure the disease process hasn't advanced, you
3 know, enough to where it's actually changed the
4 shape of the lungs or the thoracic cavity.

5 So the CT goes in. We put it through analysis
6 and then we have, we have our output.

7 This is what our reports look like. So it's a
8 quantitative and qualitative report. So you can see
9 there the heat map, which I first discussed. So as
10 those voxels are measured, there's up to around
11 10,000 different data points that will be measured.
12 That's going to vary based on, you know, patient
13 size. Depending on how much, there's columnation,
14 or depending on what area of the detector was
15 covered. But you have up to 10,000 different data
16 points are going to be measured.

17 Once those are measured, those are platted on
18 that histogram. That's what I was referencing
19 before. So one you plot those on the histogram,
20 you'll see where those data points fall, and as soon
21 as they're somewhere in that green, we'll say, okay.
22 That's the patient's mean specific ventilation.

23 Anything below 60 percent of that falls into
24 what we call the VDP, which is the ventilation
25 defect percentage. And then anything that goes, you

1 know, above whatever that mean specific is -- sorry,
2 that your ventilation defect percentage is going to
3 be the areas that are underventilated and that will
4 come out in red, as I said before. And then, of
5 course, anything above that is going to be in the
6 blue.

7 And then from there, we do calculate tidal
8 volume. And then we calculate ventilation
9 heterogeneity. So your heterogeneity won't say how
10 homogeneous are your lungs working, right? You want
11 them to all be working as, you know, the entire --
12 every bit of tissue working and, you know, together
13 as possible, but it just doesn't work like that,
14 even in a normal physiology based on just, you know,
15 gravity; that kind of stuff. A versus C basis. But
16 you want that number to be as close to zero as
17 possible.

18 And the ventilation heterogeneity, we'll say,
19 okay. This is how much difference there is.
20 There's parts of your lungs that are working really,
21 really well and maybe parts of your lungs that are
22 not. And be able -- we also show that on a small
23 and large scale as well.

24 A couple of different, you know, I guess kind
25 of advantages to it, like I said, we're able to show

1 the inside of spirometry at a much more regional
2 level. I'm not sure how familiar you were with
3 PFTs, but PFTs do provide a lot of different
4 metrics. There's, you know, a lot of information
5 that come from them, but they're very, just a
6 global, here's how both lungs are functioning. You
7 have no idea, you know, one versus the other. Even
8 lobe to lobe. So we'll be able to provide a much
9 more regional level than that.

10 Very low dose, as I stated before, in the .2.
11 You know, very high resolution, you know, like a CT.

12 Also, it's a whole thing that we can really
13 improve clinical outcomes, which I'm going to show
14 you a couple cases -- at least one case study that I
15 have that kind of shows its use case. And very
16 fast; efficient. This takes five minutes for the
17 patient to be in and out of the room and on the
18 table. Just turning around the lab, the actual
19 procedure, itself, is very, very quick.

20 And then our scans are currently priced -- so
21 we just got approved for our CPT III code, and so
22 that is, you know, which is kind of your data
23 collection code, right? That we're going to start
24 being able to submit. But if a patient were to come
25 in, our scans are \$171. So very -- priced very

1 efficiently.

2 So here's some of our clinical trials that
3 we're doing. Some of our sites that we're at. I
4 won't go through all of them, but you can see, you
5 know, some of the main academic institutions and
6 we're doing a lot of different kinds of studies.

7 So the BLVR, which is your valve placement,
8 those are where we're going to -- we image the
9 patient prior to the valve placement and see what,
10 you know, area of the lungs, how they're functioning
11 and then provide that information to the
12 pulmonologist. And then they can kind of determine
13 if they think they're going to need a valve, exactly
14 where they think they would put it, then we're
15 scanning them again post valve to see the outcome.

16 We're doing some cystic fibrosis. Doing a lot
17 of COPD. Lung transplant. And then the silicosis,
18 which is one of the case studies that I'm going to
19 show you.

20 So here is a case study that kind of shows
21 you, I guess, our technology a little bit. This is,
22 so the silicosis study is happening over in
23 Australia. And this is for the stone masons. They
24 grind a lot of the stone and they end up with pretty
25 severe silicosis exposure. And so, you can see this

1 is a 36-year-old patient who, they're undergoing
2 what's called a whole lung lavage. So they're
3 basically washing the lungs out. And they'll
4 continue to wash the lungs out over and over until
5 they almost get like a clear liquid back. And it's
6 pretty, pretty substantial for the patient to
7 undergo. It's almost like they're drowning.

8 But the procedure, they didn't really know if
9 it was very successful because it is still kind of
10 an experimental treatment, potential treatment. And
11 you can see that the CT is pretty unremarkable.
12 Three months. You don't really see much difference.
13 But the patient's symptoms were improved pretty
14 dramatically. So we did -- so one of the studies is
15 scanning the patients, obviously, pre and post. The
16 whole lung lavage. And you can see how, what an
17 improvement there is in the actual ventilation to
18 the patient. Whereas the CT, you can see a little
19 bit of improvement, not like you can't see any, but
20 it wasn't significant enough where -- we even had a
21 radiologist on staff with us at 4DMedical and he's
22 gathering, remarked it's too remarkable and you can
23 definitely see the ventilation improved
24 dramatically.

25 So one of our focuses, as I was talking about

1 all of the disease states and stuff is we -- and
2 this kind of morphed over time and wasn't one of the
3 main, original focuses is that we were conducting a
4 study at Vanderbilt with Dr. Richmond there and he
5 wanted to -- he said, I'm having a lot of these
6 veterans that are coming back and he said, we don't
7 know what, you know, they definitely have
8 unexplained dyspnea and he said, I'm doing -- trying
9 to figure out what's going on. And he was really
10 looking at constrictive bronchialitis. And with
11 that, one of the only ways to diagnose that from,
12 especially from this specific, is by surgical lung
13 biopsy, which is a pretty invasive biopsy that is a
14 three-day recovery. I don't remember the cost
15 associated with it, but extremely expensive,
16 extremely invasive and this is the only way that
17 they're able to diagnose this.

18 So he ended up having an associate that works
19 for 4DMedical. We started doing a clinical trial
20 there. And the paper was just published a couple
21 weeks ago where we were able to phenotype this
22 constrictive bronchialitis from doing a 4DMedical
23 exam. So they were able to undergo our scan and not
24 have to go through that biopsy and we can say this
25 is, you know, this is CB.

1 Now, with that, that kind of came into this
2 whole, the Pact Act and the appropriations bill
3 ended up saying that this 4D lung imaging is
4 available. So it really lead us down this path to
5 really have a VA focus and to really, really try to
6 help the veterans. We are a very veteran-focused
7 company. We have quite a few of them within, within
8 our organization.

9 And so, through some different connections, we
10 ended up, Leroy and Rosie, I don't know if you're
11 familiar with them or not, but were instrumental
12 with John Stewart in passing the Pact Act. And so
13 they are advisers to our company and huge supporters
14 and they come along with us all the time and it's
15 pretty amazing.

16 But anyway, Leroy was deployed and afterwards,
17 you know, he said, I've asked him before, I said,
18 when did you start to have those symptoms after you
19 returned? And he said, almost immediately.

20 So I guess I should kind of -- if you're not
21 familiar with burn pits, when the veterans -- when
22 the -- they're sent overseas -- and they're all over
23 the world. It's not just Iraq or Afghanistan.
24 These burn pits are all over the word. They dig
25 these giant pits and then all the military personnel

1 are told they put everything in there. Everything
2 from, you know, from medical waste to human bodies
3 to tires, computers. And then they use jet fuel to
4 burn it. And it burns 24-7 right next to where they
5 sleep. All the time. And they're exposed to this,
6 you know, usually during most of their entire
7 deployment.

8 And so anyway, so when Leroy came back, he
9 said, I can't breathe and nobody could explain it.
10 Nobody could understand what it was. His chest
11 x-rays were pretty unremarkable. CTs were
12 unremarkable. And so he ended up -- he was a police
13 officer -- ended up losing his job. And then from
14 there, they started Burn Pit 360 and have really
15 just brought a ton of awareness to it. Helped pass
16 the Pact Act.

17 And then we have since been able to team up
18 with them and really try to move this forward and
19 see if we can get into the VAs and be the technology
20 of choice to help them not have to undergo that
21 surgical lung biopsy.

22 So kind of where we're headed as a company is
23 we created a whole new modality, which you guys were
24 talking about machine registrations earlier. When I
25 got here, I was like, oh, wow, this will be a whole

1 new world for us as well, right?

2 So we, getting into those labs is -- which
3 wasn't our main focus, but this was actually from a
4 huge grant that was won in Australia quite a few
5 years ago how this project started. But we
6 basically created a scanner that has four
7 fluoroscopy tubes in it and then you're basically
8 taking that exposure that I was explaining to you
9 before at the five different angles, but this one is
10 with four instead of five and we're just imaging it
11 during one full breath, instead of having to do the
12 five different times.

13 So this scanner is at the University of South
14 Wales in Sydney. And it's getting ready to
15 hopefully have its first patient scan in the next
16 few weeks. We're waiting on an ethics board review.
17 But it was showcased last year at RSNA for being the
18 eighth modality. Brand new modality. And so we're
19 hoping, you know, that this is going to be something
20 that will be available for any clinician, really,
21 but that will help them be able to have a much, for
22 one, you know, easier work flow, faster patient
23 throughput. If these could, you know, live in
24 offices where you have a lot of these, whether
25 there's veterans, occupational exposure, all of

1 those kinds of things is definitely something.

2 But we're supposed to, after we get through
3 getting it into the U.S -- the actual, you know,
4 operating one, it will be -- we have two being
5 placed. One at University of Miami and at
6 Vanderbilt. So all that, basically, is in place as
7 soon as we can get it through customs. And then
8 this one will be at RSNA again this year.

9 So kind of from there, so that's one of our
10 huge products. And then we are currently TGA
11 cleared for a CTV product. It's exactly like I was
12 telling you before about measuring ventilation but
13 it's a CT based. We would take out the fluoro. Now
14 you do a paired CT. So an inspiration-expiration.
15 And we measure from peak to peak. And then that's
16 one of our products.

17 And then from there, we have what we're hoping
18 to be submitted to FDA by the end of the year, maybe
19 by RSNA, which is CTVQ, which is perfusion. And
20 that's what we're really, really looking for where
21 we really think we can kind of, I don't know. I
22 won't say compete with nuclear medicine, but
23 hopefully we can provide a much -- so it would be
24 completely, once again, non-invasive; no contrast
25 and a very quick scan that would be, you know, be

1 able to show ventilation and perfusion with the VQ
2 product.

3 So that is in major research stage right now
4 where the whole company is like, unless it's a talk
5 about VQ, it's really not happening right now. It's
6 extremely important and where we're headed.

7 But so, that's kind of, like I said, what's
8 happening. And, yeah, those are my references. I
9 know it was kind of a big overview and it's like a
10 lot, but I wanted to leave a few minutes for
11 questions. So, yes.

12 RANDY SCHENKMAN: I have two questions. With
13 this future product, why only four images instead of
14 five?

15 HAILEY KIRBACH: So you can -- so the truth is
16 we can get a reading with three. Would give us --
17 but for more, for accuracy, I mean for full
18 accuracy, 180 would be ideal, right? But we
19 definitely learned, okay, we can get a definite
20 reading with three. Five gives us we know, you
21 know, even better. But four is completely adequate
22 to give us the same amount of information.

23 RANDY SCHENKMAN: And then with this CTVQ, are
24 the images going to be similar? When you finish --
25 I mean, I know you'll have the slices, but then is

1 it going to put it into the same kind of a full lung
2 image like these were?

3 HAILEY KIRBACH: I think that's a great
4 question and I actually love your feedback. So
5 we're talking right now to our radiologist
6 consultant as well as a couple other and we look a
7 lot -- I'm not sure if you're familiar with
8 Polarean, the hyperpolarized MRI. So we're trying
9 to look and see, we don't want to produce images
10 that look totally different than what, what they're
11 used to looking at, right? I think just getting
12 that adaptation is a little bit harder.

13 So right now, we're going to kind of go with
14 the same kind of color scheme as a VQ scan. So more
15 the purples and oranges. And produce it on a very
16 similar CT overlay just like that. I mean, it
17 wouldn't be an overlay at that point, because it's
18 actually a CT product. But, yeah, there will be
19 some variations, but very similar I think is what we
20 are planning on.

21 RANDY SCHENKMAN: Thank you.

22 HAILEY KIRBACH: Anybody else?

23 MARK SEDDON: Do you guys --

24 CHANTEL CORBETT: How are you getting the
25 perfusion portion?

1 HAILEY KIRBACH: So basically, measuring the
2 blood, like the actual density of the blood. Being
3 able to tell that, you know, just like we're kind of
4 measuring the, the air.

5 CHANTEL CORBETT: Right.

6 HAILEY KIRBACH: We're going to actually look
7 at the density in the blood.

8 MARK SEDDON: Do you have limitations on your
9 patients as far as, like, heart rate limitations,
10 their lung volume limitation? What is actually a
11 effective range for the software to be functional?

12 HAILEY KIRBACH: We do not.

13 MARK SEDDON: Okay.

14 HAILEY KIRBACH: Our only restriction right now
15 is we're not approved for pediatrics, but other than
16 that, everything else.

17 MARK SEDDON: Is there accuracy issues when it
18 comes to high heart rate? Since your, you know,
19 arterial flow and everything else.

20 HAILEY KIRBACH: You know, I think that that's
21 a great point as far as -- I don't know that we
22 have, that we have the database yet to one hundred
23 percent answer that.

24 NICHOLAS PLAXTON: I've got a question similar
25 to that. Like, if you're looking at a lot of COPD

1 patients. Emphysema, they have tend to have
2 expanded lungs. Do you run into problems of them,
3 the lungs are to big for the C-arm?

4 HAILEY KIRBACH: Yep.

5 NICHOLAS PLAXTON: How often does that happen
6 with that?

7 HAILEY KIRBACH: I don't know if I really have
8 a number to say how often. I would say not often
9 enough where it -- because we notice you have a -- I
10 mean, you're going to have a little bit of that
11 ventilation analysis -- I guess the word escapes me
12 -- where you're not going to have -- the ventilation
13 is not going all the way to your periphery anyways,
14 right? So if we're clipping a little bit of that,
15 it seems to be okay.

16 What we do notice with severe emphysema is if
17 you have such, you know what I mean, emphysema
18 changes -- I can't say that word all of a sudden --
19 that our software, it just looks like the tissue is
20 not moving at all, right? It doesn't even look like
21 lung tissue because it's so severe; so fibrotic
22 that, that we definitely, you know, we've noticed
23 that sometimes.

24 So then what -- which is not a problem for us,
25 we can go in and manually fix those through, you

1 know, through manipulation of the software. But as
2 far as the actual program running, if it's a severe
3 state, you can definitely, definitely see where it's
4 like, that doesn't even look like lung tissue.

5 JOSEPH DANEK: Have you done any imaging for
6 patients that are, people that have asbestosis?

7 HAILEY KIRBACH: We have not. We have not, no.

8 JOSEPH DANEK: That is a big deal too.

9 HAILEY KIRBACH: That is a big deal, yeah.
10 Sure.

11 KATHLEEN DROTAR: Hailey, from the time that
12 you do the scan and it goes through the software,
13 how long of a timeline is that before you can
14 actually see the reading and get the results?

15 HAILEY KIRBACH: So basically, I mean, we tell
16 them eight hours. Just to kind of give, you know --
17 but we can basically turn a report around in about
18 thirty minutes or less. So -- and with VQ, it's
19 going to be instant because these are, you know,
20 these are PE patients. We need to make sure we can
21 have something back almost immediately.

22 So that's going to be another big push for our
23 software that's it's like, we won't release this
24 product until we can tell an ED doc, oh, no, this
25 would be an instant result. You'll have the report

1 back within minutes. So, yeah, it can easily be
2 done in about thirty minutes.

3 You know, part of our work flow of taking
4 images out, sending them to our cloud, bringing
5 images back in is, to be honest, one of our biggest
6 struggles. You know, it's an IT workload that is
7 extensive but, but, yeah. So we always kind of give
8 a little bit of buffer. But the actual, you know,
9 at the spoke, at our hub where our, where it lives,
10 it can run it rather quickly.

11 CHANTEL CORBETT: So is the plan to have that
12 IT portion in house for every client?

13 HAILEY KIRBACH: No. We still plan on keeping
14 it -- no. So we team up right now currently with a
15 company called Laurel Bridge and Laurel Bridge will
16 build a VPN. And that will basically come out of
17 the hospital, you know, to our site router. And
18 then, everything is de identified before it leaves
19 the facility. I mean scrubbed like, completely to
20 where, you know, it's a little -- sometimes like,
21 wow. We got rid of, you know, like almost
22 everything. But it's all de-identified. Goes, runs
23 and then comes back in through them.

24 So there's a lot of different companies right
25 now. Laurel Bridge we use to do that. But that's

1 still the plan, to keep on that, that work flow
2 where we will send it up that way.

3 MARK SEDDON: So does your existing vendor
4 prefer Philips? I mean, are you working with
5 Siemens, GE, all the different ones?

6 HAILEY KIRBACH: We work with all of them.
7 Right now, VA wise, yes, Philips. I had the most
8 success with Siemens, just as far as they didn't
9 need any alterations to the tags, everything is kind
10 of there, everything seems to fit the
11 specifications. But -- and then I don't have a ton
12 of GE C-arms that I even come across with the C-Arms
13 that I had to really work with.

14 I just had a Canon one that came through that I
15 had to try to qualify. And their DICOM conformance
16 statement, they don't carry some of the normal tags
17 that we would need in order to run our software.
18 But with VA focused, yes, Philips is going to be our
19 main.

20 MARK SEDDON: Geometry accuracy, is that based
21 off of CT? How are you getting --

22 HAILEY KIRBACH: Geometry is CT.

23 MARK SEDDON: CT is doing the geometry. Okay.

24 HAILEY KIRBACH: Yep.

25 NICHOLAS PLAXTON: As a nuke med physician, I

1 hope you guys get the VQ thing squared away, because
2 I'd like to move away from that.

3 HAILEY KIRBACH: Yes.

4 NICHOLAS PLAXTON: I mean, obviously, CTA has
5 taken most of it, which is good and it's very quick.
6 But the VQs are -- we don't do as many. When we do
7 do them, it's like we have to get the radio doses
8 sent in, so it's usually three-hour turn around
9 time.

10 HAILEY KIRBACH: Yes.

11 NICHOLAS PLAXTON: That would be good.

12 HAILEY KIRBACH: We would love to see that. So
13 we use the analogy that CTA, you know, is kind of
14 like crack to the radiologist. So we're going to
15 have to get them off of that. But hopefully, the
16 fact that, you know, those that, you know, anybody
17 that has a contraindication to contrast, that's our
18 big, you know.

19 NICHOLAS PLAXTON: That's what we get.

20 HAILEY KIRBACH: That's a big one right there.

21 All right. Well, thank you guys so much. I
22 actually told a couple people I'm going to hop out.
23 I do have a meeting with the Philips people. But,
24 yeah. I'm going to be just in the lobby. I'll be
25 here until I think you guys are finished. If

1 anybody else would have any questions, let me know.

2 All right?

3 RANDY SCHENKMAN: Well, thank you very much.

4 (Applause)

5 RANDY SCHENKMAN: Fascinating.

6 Okay. Now, Kevin, your turn.

7 KEVIN KUNDER: My turn.

8 RANDY SCHENKMAN: Radioactive materials update.

9 KEVIN KUNDER: Okay. Radioactive materials.

10 I'm the administrator of radioactive materials.

11 We have 12 FTEs, and I've now recently got a
12 part-time consultant that's helping out with our,
13 with our workload --

14 I am down one regulatory specialist. My
15 regulatory specialist, Michael Jefferson, left about
16 a month ago and he was kind of my junior evaluator,
17 so we've got that position open. Last interview is
18 this Thursday, so we'll get somebody hired for that.

19 I was down a regular licensed evaluator, ES3,
20 and I hired Morris Sanders about three, four weeks
21 ago. And he comes to us with seven years of Navy
22 nuclear background. He was on two different nuclear
23 subs, the Bergall and Helena. Then he went up to
24 Connecticut and worked for 33 plus years at
25 Millstone Nuclear Power Station where he did

1 everything from being a nuclear power plant operator
2 to emergent preparedness specialist. He'll help out
3 in other areas other than just materials when we do
4 power plant exercises and things like that.

5 As of last month, our numbers were 1525
6 specific licenses that we have and 238 GLs. So
7 we've got a total of 1763 radioactive materials
8 licenses. We average about 200 licensing actions a
9 month and we average about 50 to 75 ram inspections
10 a month that we process and turn around and get the
11 letters out to our licensees about the inspections.

12 Just a couple follow ups from, I guess last
13 meeting I wasn't here. Check-Cap we had come in and
14 do a presentation about their colonoscopy horse
15 tablet that you swallow and it takes x-rays
16 throughout and stuff. That company, I think the
17 month after he was -- they did the presentation,
18 June 6 they announced that they were going to look
19 into strategic alternatives, which was a sale or
20 merger and reduction of the work force about 90
21 percent. So that was -- the guy that was from
22 Washington State, he is gone, so they've just kind
23 of gone down.

24 I did look out and on August 16th, they just
25 posted on their website that they've entered into an

1 agreement with Keystone Dental Holding. So they're
2 going to buy them out and they're going to work on
3 marketing developments of their implants and arches
4 and other tooth replacements, which includes
5 prosthetic solutions, biomaterial and digital
6 dentistry.

7 So that's what they're going to be working on
8 now. So I don't know what's going to happen with
9 that. But any of the shareholders who happened to
10 be in with the Check-Cap, they're going to become, I
11 guess, 15 percent ownership in the combined company
12 going forward.

13 So the other thing that I guess came up last
14 time was the extravasations and the NRC extended
15 their comment period until September 1 to get, I
16 guess, more stuff in. I have not heard anything
17 since then with what they've gotten through. The
18 only thing that they have posted right now is just
19 proposed rules and guidance by this time next year.
20 And then final rule adopting is spring of '26. So
21 sorry for that.

22 Let's see. IMPEC. Clark mentioned about our
23 integrated materials performance evaluation program.
24 Just like our licensees have our inspectors come in
25 and do our inspecting because we're -- because we

1 are an agreement state with the NRC, they come in
2 every four years to do -- well, if we're good, they
3 come in every four years to come in and do an
4 evaluation of our program. They were in 2019 when I
5 started and they found -- and again, with the NRC
6 and their things, satisfactory is a good thing. So
7 you get satisfactory, you get unsatisfactory. And
8 then they make different types of comments along the
9 way.

10 So in 2019, we had technical staff training, we
11 were satisfactory; no recommendations. Status of
12 inspection program, same thing. Satisfactory; no
13 recommendations.

14 Technical quality of inspections, we were
15 satisfactory, but we needed improvement. Technical
16 quality of licensing actions, which is what I do,
17 satisfactory, but also needs improvement.

18 Technical quality of incidents and allegations,
19 our Orlando office takes the calls for any incidents
20 that get called in and any concerned citizen or any
21 allegations that comes in. That was satisfactory
22 and no recommendations.

23 Compatibility, which is now called LROPE for
24 Legislature -- Legislation Regulation and Other
25 Program Elements -- we were unsatisfactory and they

1 made several recommendations on that.

2 And the last thing they looked at was sealed
3 sources and device evaluation program and we were
4 satisfactory and no recommendations.

5 Since that time, remember Cindy Becker, her and
6 I went up. The IMPEP comes in. They do the review.
7 They give out a 25-page report. We review it.
8 That's the draft. They submit that to what they
9 call their MRB or management review board. Clark
10 and I are going up there in less -- maybe two weeks.
11 And that's when they either agree with what the
12 IMPEP found or not. They'll review with us and we
13 can talk and discuss what's been done since this was
14 done in June and they'll make recommendations as far
15 as what they're going to do.

16 But the team that was here, they went through
17 the same group of things and we were all
18 satisfactory with no recommendations
19 across-the-board, with the exception of the LROPE or
20 the compatibility. So we're -- we made
21 improvements, but we're still not there yet.

22 We did get everything to legal; gone through
23 our whole process, but we are kind of gone back and
24 forth with legal right now. As Clark mentioned
25 earlier, they're now asking us. We just had this

1 big rule package that we dumped on them. They're
2 asking that we, you know, do it in chunks next time
3 and make it a little bit smaller. We're trying to
4 get the stuff done. We're hoping to get it done
5 before we went up there. It doesn't look like
6 that's going to happen, but hopefully, we're going
7 to be real close to finally getting that out there.

8 I'll talk about -- we did go through and in the
9 interim, there are a couple license conditions that
10 we got approved by the NRC that we can add to the
11 license to make us a little more compatible. I'll
12 talk about that in a minute.

13 Medical events since last time we were here, we
14 have none. We had three incidents that were called
15 in as far as the wrong dose being delivered to the
16 patient, but they didn't meet the criteria for a
17 medical event.

18 We had two leaking E-vials that were called in
19 and we had two concerned citizens calling in about a
20 radio pharmacy and imaging center that we went out
21 to investigate. They were unfounded what they had
22 called in. I think a couple former employees that
23 were kind of upset with what was going on. That's
24 it for that.

25 So what we were looking at is on your --

1 anybody who has a medical license with us, we will
2 be, probably until we get these other rules done and
3 adopted, we're going to make a couple changes just
4 with -- the license conditions, we're going to add a
5 couple license conditions on to your license; make
6 it a little bit longer, but it will take care of the
7 transportation becoming one with the DOT
8 regulations, 10 CFR part 71 to the IAEA
9 requirements.

10 And for the medical ones only, I guess the
11 Committee on Post Graduate Training of the American
12 Osteopathic Association has been renamed the Council
13 on Post Doctoral Training of the American
14 Osteopathic Association. So to take care of that.

15 And also, I don't know how many people get
16 medical events that, and doses to embryos and
17 fetuses, but there has been a change that the NRC
18 wants us to do, which is if you do not have another
19 means of providing a medical record number or some
20 kind of number for that embryo or the fetus, they
21 want us to include a Social Security number and no
22 other IDs are used. So that will be the two things
23 on there.

24 CHANTEL CORBETT: What? Sorry. How are you --

25 KEVIN KUNDER: I know, because they don't --

1 embryo and fetuses aren't going to have Social
2 Security numbers.

3 CHANTEL CORBETT: Are we talking about the
4 mom's Social Security number?

5 KEVIN KUNDER: No. Medical events and doses to
6 embryo and fetuses. They want it annotated on the
7 report. If you're doing a report, annotative it on
8 the report. They want them to include a Social
9 Security if no other ID numbers are used.

10 CHANTEL CORBETT: It's got to be mom. There's
11 no physical way to have --

12 RANDY SCHENKMAN: You can't get a Social
13 Security number until you're born.

14 KEVIN KUNDER: So you're saying that they
15 mean -- use the mother's Social Security number.

16 NICHOLAS PLAXTON: Most likely.

17 KEVIN KUNDER: Okay. That's --

18 KATHLEEN DROTAR: That's the location of the
19 embryo.

20 NICHOLAS PLAXTON: Unless the rule has changed.
21 Maybe you get it before you're born.

22 KEVIN KUNDER: Okay. They must mean the
23 mother. Okay.

24 Also, for, for becoming an AU, they're gonna do
25 away with the designation for --

1 CHANTEL CORBETT: Multiple. For American Board
2 of Radiology?

3 KEVIN KUNDER: Yeah, for the American Board of
4 Radiology, they're going to do away with the AU, the
5 RSO, the AMP, the AUT and AUD eligible --
6 eligibility. That's not going to be on there
7 anymore. So if you're trying to get somebody brand
8 new on a license as an authorized user and you've
9 been providing that, it's still to be going through
10 to the end of the year. They're still doing that to
11 the end of this year. As long as somebody is trying
12 to get on the license within the next seven years,
13 we can still use those. But after, after the end of
14 this year, they won't use that anymore. So you
15 won't be able to do that. You will have to do an
16 alternative pathway to get on there.

17 CHANTEL CORBETT: So basically, you still just
18 use the long form.

19 KEVIN KUNDER: Yes. Exactly.

20 MARK SEDDON: I think also, any renewal
21 certificates also won't, no longer have, either.

22 KEVIN KUNDER: Correct.

23 MARK SEDDON: For NRC.

24 KEVIN KUNDER: The only thing with that is just
25 that the NRC is preparing to implement guidance, but

1 that probably won't be out for a long time.

2 CHANTEL CORBETT: Right.

3 KEVIN KUNDER: But, yeah. So that was --
4 that's all I got.

5 RANDY SCHENKMAN: Anybody have questions?

6 Okay. James?

7 JAMES FUTCH: I think we should take a moment
8 to commemorate possibly the longest update we've
9 ever gotten out of materials.

10 (Laughter)

11 JAMES FUTCH: In a highly efficient manner as
12 well.

13 CHANTEL CORBETT: Good job.

14 JAMES FUTCH: The afternoon down slope
15 galvanizes the imagination.

16 KEVIN KUNDER: I had lunch, so that might have
17 been it.

18 JAMES FUTCH: Okay. So over to me now, right?

19 RANDY SCHENKMAN: Yep.

20 JAMES FUTCH: All right. We'll start with
21 personnel. Clark touched on it for the technology
22 section. We lost the, the -- one of the staff --
23 well, I have six staff. Two of those are
24 programmers; one of them is another IT person, one
25 administrative assistant person we call government

1 operations consultant and then the two Rad Tech
2 individuals.

3 So the CE coordinator is vacant at the moment.
4 One the programmers is vacant and the administrative
5 support person, which is really at the moment, the
6 most crucial, because that keeps the other ones
7 going and the plates spinning in the air.

8 But we're doing well. That position I would
9 expect to be filled in the next week or two. And
10 that means somebody else is probably losing a staff
11 person because they came internally. The
12 applications. Hint hint.

13 One of the things that we've been taking care
14 of is the laser side of the shop. The government
15 operations consultant was handling a fair amount of
16 that with me. Kelly has stepped in and learned a
17 whole new aspect of the radiation world. And I am
18 now seeing laser light show notices for groups I
19 don't even understand what the initials mean, much
20 less what the music sounds like. So that was a
21 joke. That's okay.

22 (Laughter)

23 JAMES FUTCH: But the laser side of the shop,
24 which we don't talk about very much, has a
25 registration requirement for high-powered lasers,

1 which really, the most important aspect of that is
2 people who want to follow the law, we point them in
3 the direction of the ANSI standards for the safety
4 use of lasers. It's incorporated in the Florida
5 regulations.

6 The other half of it is if medical professional
7 folks licensed by the department don't use a laser
8 that's not registered, that's grounds for discipline
9 of their medical license. So that, that's moving
10 along smoothly.

11 I wanted to show you, hey, we had a hurricane.
12 So that means, we have an executive order. And
13 pretty much this is me saying, every time there's a
14 hurricane anywhere in Florida and some part of the
15 population has to move or be affected by it, there's
16 going to be a Governor's executive order and there's
17 going to be a Surgeon General following up on the
18 authority of that order and somebody's license is
19 going to get extended to whichever part of the
20 calendar the department happens to be renewing at
21 that particular time of year. If it's nurses, it's
22 three times a year. Most of the other professions,
23 it's one particular time during the year. Rad
24 Techs, it's every month.

25 So every time there's a hurricane or something

1 that causes an emergency that restricts peoples'
2 ability conceivably to get to renew the license,
3 whatever it is they need to do just to get online,
4 like you're trying to do on the front end, you're
5 going to see one of these. This particular one came
6 out, and you get through all the whereas clauses.
7 It affected mobile pharmacies, prescription drug
8 monitoring reporting and then renewal extensions for
9 these three different professions covered by these
10 three different statutes. This one is the Rad Techs
11 right here.

12 And basically, it's executed this 28th day of
13 August, and for these folks, it authorized an
14 extension of the upcoming renewal deadlines until
15 October 2nd, 2023. So that means the August
16 deadline -- those folks whose licenses, Rad Techs
17 who should have expired the end of August, won't
18 expire until in the month of October.

19 Theoretically, the people who expired at the
20 end of this month also got an extension, but not
21 really all that much. Like, you know, a couple
22 days. We will be gracious, I'm pretty sure if we
23 have any inspectors who go into the field and find
24 folks working on expired licenses, they're not
25 really, if you check them out online, it should say

1 what their actual license is. So that's for the
2 employees as well.

3 And it's really fun keeping up with these, too,
4 because it's just like luck of the draw, what
5 particular month is it, what time of the month is
6 it, where does it cover? Let's go figure out which
7 professions are affected. I have no idea. I guess
8 it's massage therapists and massage therapy
9 establishments.

10 All right. Let's see. Enforcement data.
11 Let's do this one. Enforcement data. You remember
12 at the last meeting, I took you through a historical
13 look back for the past several years of not just
14 which particular Rad Techs are in various forms of
15 enforcement. Meaning that they've been reported on
16 a complaint or that they're somewhere in the legal
17 process, or they've been disciplined or there's a
18 final order they're supposed to be following.

19 At the last meeting, we went down into the, not
20 just the numbers, but the incidents, and looked at
21 the different ways, you know. I'm not doing that
22 again, so you can breathe easy. So this is just
23 basically the fourth quarter. This is finishing out
24 the quarter. It would've been just about to go into
25 the other, halfway through the quarter last time.

1 We started out with I think about 72 open cases
2 in various stages of legal process. In the fourth
3 quarter, we opened 15; we closed 25. Hey, that's
4 good. We're plus ten overall at that point, right?
5 This quarter, starting July 1, through wherever
6 we're at this month, we are, looks like open date,
7 three more. So we're plus 13. So we're down to 59
8 cases open. And it's okay. It never goes to zero.
9 That would be nice. We're no where close to zero.

10 But currently, 59 cases open. And because you
11 can report technologists for multiple violations,
12 there's actually 54 technologists involved in 59
13 cases. And here's the snapshot of incidents for
14 just these cases and how that breaks down. You can
15 see the more popular categories here on the right
16 and the less popular categories.

17 This was an interesting one. Whenever -- this
18 profession doesn't do fingerprinting or background
19 checks at the department level. So everything on
20 the application is on the honor system if you want
21 to tell us that you've been convicted of whatever in
22 the past. However, if we license you and you get
23 out in the real world and you work in the facility,
24 you get fingerprinted and background check to work
25 at the facility, that gets reported to AHCA and they

1 find out if you're lying to us or not. That
2 occasionally happens.

3 In this case, what that results in is a
4 complaint of possible licensure fraud, obtaining a
5 license by fraud because you lied about it on the
6 application. You said you had no history that was
7 reportable, and yet when the fingerprints came
8 through, AHCA said you can't work until you get an
9 exception from your licensing agency for this
10 offense. So it comes back to us as the licensing
11 agency. The same for all the health care
12 professions. Not just Rad Techs.

13 And normally, this is not a hard issue for us
14 because if the folks are honest, we'll completely
15 evaluate what the criminal history is, all the
16 mitigating, aggravating circumstances, how long ago,
17 how often, how severe effect on the person that
18 was -- that had the crime committed. And if we
19 decide to let them in, we're going to automatically
20 grant the AHCA exemption when that comes back to us
21 a little bit later, unless, of course, they don't
22 tell us about it. In which case, we probably won't
23 grant the exemption.

24 In some, in some statutory situations, like
25 what happened this past quarter, there's a part of

1 the law that the agency doesn't have any discretion
2 to grant an exemption and one of them is, this is
3 one of the most common one that happens, at least in
4 our experience with Rad Techs is if you have
5 committed a felony and you're -- you paid your time,
6 you've paid your money, you're off probation -- you
7 have to be off any kind of supervision for three
8 calendar years before you could be licensed by the
9 department in any capacity for health care. And
10 that's a pretty big one if you think about it.

11 And that's what happened this time.
12 Unfortunately, it was one of these licensure frauds.
13 So he didn't actually tell us about anything on the
14 front end. So we didn't really get the opportunity
15 to say, you know, we might have considered doing
16 this, but we couldn't have granted it anyway because
17 of the three years. He is still on probation for
18 another two years, this particular individual. So
19 he's, like, five years away from being able to go
20 practice in his profession as a Rad Tech at whatever
21 facility he applied to or any facility in Florida.

22 The most common category, national licensure,
23 other state takes some discipline by somebody who's
24 licensed in Florida, category number two,
25 disciplined in this case by ARRT.

1 ULA, unlicensed activity, we used to call this
2 NCO, non-certified operator. MqA calls it
3 unlicensed activity. So these are individuals who
4 have been found sometimes by our inspection staff,
5 sometimes just reported by, you know, angry
6 ex-spouse, you know, whoever it is, for working
7 without a license in the State of Florida. And
8 occasionally, the employer is pulled into that
9 because there's a part of the statute that makes it
10 both a crime and grounds for discipline for the
11 employer to employ such a person.

12 Various kinds of impairment like we talked
13 about last time. The ones -- various kinds of
14 unprofessional conduct, of which there's impairment
15 and falsification of records, and then everything
16 else, kitchen sink, UPC, ten cases.

17 This is one that we really don't like to see,
18 which is, you have a complaint against you; it goes
19 through the process of being evaluated, it goes to
20 prosecution; you get prosecuted. It ends up as a
21 final order. Maybe it gets appealed to a hearing
22 officer.

23 Anyway, you eventually come back to the final
24 order, the terms of which you have to abide by and
25 then you don't. So those eight are most often

1 somebody who didn't pay a fine or didn't do a
2 medical errors course, which drives us all nuts
3 because it takes a lot of time and effort to pull
4 the lawyers back together with, you know, the staff,
5 and go back and say, what do you want to do with
6 these people? And so, we really don't like to see
7 those.

8 And then just four that are characterized as
9 other things that I didn't want to keep going down
10 to the minutia with.

11 So that's the enforcement data for this
12 quarter. That's as of the middle of last week.

13 Any questions on this?

14 KATHLEEN DROTAR: James, do you find that
15 because in the statutes or rules or whatever, it
16 says that if you have -- if you, you know, get a
17 misdemeanor or felony, that you need to report to
18 the State within 30 days, do you find -- have you
19 seen that does or doesn't happen?

20 JAMES FUTCH: I would say it doesn't more often
21 than it does. Usually, we find out about those
22 because people are reported to ARRT. And there's a,
23 there's a large number -- I shouldn't say -- there's
24 a non, insignificant minority of technologists who
25 think we are ARRT. That we are the same

1 organization.

2 KATHLEEN DROTAR: Yes. Most do.

3 JAMES FUTCH: When they report, they think,
4 I've reported this. And eventually, we find out
5 because ARRT tells us, but that's how it works.

6 KATHLEEN DROTAR: ARRT, on the initial
7 application, we're finding they do their own very
8 in-depth background check as well, because we've
9 had, had a student who had -- her bumper was too
10 high and she got a ticket for it. And it was 25
11 years before, but she didn't report it. So ARRT
12 told her about it, but she didn't remember that it
13 happened.

14 JAMES FUTCH: Yeah. We get a, we get a fair
15 number of folks who had something happen many years
16 ago.

17 KATHLEEN DROTAR: Yeah. Can't make it up.

18 JAMES FUTCH: Also, another common thing that
19 happens is the wording you use on these
20 applications --

21 KATHLEEN DROTAR: Yes.

22 JAMES FUTCH: We'll say, have you ever been
23 convicted, which has a specific meaning, or pled no
24 contest or had adjudication of guilt withheld for
25 any offense in any jurisdiction. That's about as

1 broad as the lawyers I guess can think to ask the
2 question. And people will still think you mean
3 convicted for all those things. And it's like, no,
4 it's a little broader category than that.

5 I wanted to follow up with one little
6 additional piece of news. Let me find it here. So
7 you may recall we spent a fair amount of time in
8 some past meetings talking about changing
9 regulations to comply with CE consensus standards
10 for ARRT so that we have uniform standards and the
11 CE you can use here and use elsewhere, so forth and
12 so on. And that we had become recognized by ARRT as
13 their category of CE approver. Which means that you
14 can do -- because you comply with the standards, you
15 can have your CE evaluator.

16 We were the first state to do this and turns
17 out it was for a three-year period. And the three
18 years flew by, so we had to go through the
19 re-recognition process. And we just got word back
20 from the ARRT that -- I'll throw it up here on the
21 screen. Congratulations on your continued
22 recognition. Yay. I like to think of it as
23 reaccreditation, because that's what it felt like.
24 And this is for five years, so --

25 KATHLEEN DROTAR: Yay.

1 JAMES FUTCH: Possibly I will not be here the
2 next time this has to be done.

3 CLARK ELDREDGE: You won't be here. I won't be
4 here.

5 CHANTEL CORBETT: So just to confirm --

6 JAMES FUTCH: Camilla and you and whoever else
7 wants to come handle this, can do this.

8 CHANTEL CORBETT: James, just to confirm, this
9 means like if the State of Florida approves the CEU
10 hours, then it's automatically accepted by ARRT?

11 JAMES FUTCH: That's the idea. This goes into
12 greater detail and describes --

13 KATHLEEN DROTAR: But that's if you are a
14 Florida licensed technologist.

15 JAMES FUTCH: Yes, there's always that
16 category.

17 KATHLEEN DROTAR: Yeah. If you're out of
18 state, it doesn't count.

19 JAMES FUTCH: Exactly.

20 CHANTEL CORBETT: Really?

21 KATHLEEN DROTAR: Yeah. Like when we do our
22 meetings, we apply --

23 CHANTEL CORBETT: I know it was. I was hoping
24 this would go like that. We do have some Georgia
25 techs that like to come down to the meetings.

1 JAMES FUTCH: Yeah. We live in states that
2 border other states. You would think that would be
3 nice. But please feel free to petition your ARRT
4 senator and representative living in your area,
5 which there's probably none because such doesn't
6 exist.

7 KATHLEEN DROTAR: It's very confidential.

8 JAMES FUTCH: And see if you can, you can
9 convince the private organization that's living up
10 in Minnesota -- just tell you what, you see a change
11 in leadership in the past couple years.

12 KATHLEEN DROTAR: Just this year.

13 JAMES FUTCH: This year? It continued on. I
14 have one person left that I know up there. And she
15 was supposed to be retired this year and she was not
16 allowed to. They decided to keep her on for
17 another, another little while while the additional
18 staff who were hired to replace her learn how to do
19 things.

20 So this is the categories of things we can
21 approve, which is most everything, and these are the
22 subjects. Thank you to everybody who's not in
23 radiography and nuclear medicine, or that is and
24 works on our staff, for lending your subject matter
25 expertise to our efforts and being available when we

1 need you -- especially Council members -- because
2 some of these things don't come along very often
3 that we have to take a look at.

4 KATHLEEN DROTAR: While you're on that, too. I
5 just want to say --

6 JAMES FUTCH: You want to be paid now?

7 KATHLEEN DROTAR: Thank you to Kelly or whoever
8 RAD CE is because we had our Florida annual
9 conference this past weekend. And we submitted -- I
10 submitted 12 different continuing education credits
11 and Kelly had them back to me with the approved
12 forms within 48 hours. So much appreciated.

13 JAMES FUTCH: It is definitely Kelly. So we
14 should -- I'll give her a big thank you from you
15 guys when we go back.

16 KATHLEEN DROTAR: Okay.

17 JAMES FUTCH: Because that's the job she can't
18 quite get rid of.

19 KATHLEEN DROTAR: Yeah, she does it so well.

20 CHANTEL CORBETT: She keeps doing it so well.

21 JAMES FUTCH: She keeps training new people,
22 giving it over to them, they hang around for a year
23 or two and then they're gone somewhere else. But we
24 bumped it up. Maybe we'll hold on to somebody a
25 little longer this time. And then I had one more

1 thing.

2 KATHLEEN DROTAR: Yeah.

3 JAMES FUTCH: Something that one of the Council
4 members had brought up. It is -- let me find where
5 I stored this. Just a second.

6 So it is coming up. The November 8th
7 anniversary of William Roentgen's discovery of
8 x-rays. And it's a tradition in a couple of the
9 different radiation professions, that week is called
10 National Radiation something week. This year, the
11 week falls on the November 5th week. It's a
12 Wednesday, November 8.

13 So a suggestion was made, and I drafted up some
14 language that the Advisory Council consider. I
15 think somebody probably will have to make a motion
16 and then we'll have to have discussion and we have
17 to vote on it if you want to do this, but the
18 Chair's given me liberty to --

19 RANDY SCHENKMAN: Yes.

20 JAMES FUTCH: -- to read this. And if anybody
21 sees an error, tell us quick. But I think it's
22 right.

23 Basically, the idea is to have the Council,
24 itself, like ASRT does, like CRCP does, probably
25 other folks in other professions do, maybe NTCB

1 does, probably not x-rays, is to have this
2 resolution be voted on and accepted by, by the
3 Council for thanking the folks who keep radiation
4 imaging and therapy and protection and all the
5 different little sub worlds, medical treatment, all
6 the rest of it going.

7 So we've got --

8 RANDY SCHENKMAN: Kathy, this is for your
9 question to us.

10 KATHLEEN DROTAR: Yes. Thank you.

11 JAMES FUTCH: So we have, we've got Becquerel,
12 we've got the Curies, we got Roentgen in there. We
13 state obvious things about being useful. We state
14 obvious things about it can be harmful. We work in
15 all sorts of sectors; provide expertise.

16 I don't know if somebody wants to actually read
17 this into the record.

18 CLARK ELDREDGE: Want me to actually read it
19 out loud for you?

20 JAMES FUTCH: Not me, because I speak softly.

21 CLARK ELDREDGE: Yes, you do.

22 JAMES FUTCH: Jump in then.

23 CLARK ELDREDGE: Okay. So Advisory Council On
24 Radiation Protection. Resolution. National
25 Radiation Professionals Week, November 5th through

1 11th, 2023.

2 Whereas, William Conrad Roentgen discovered
3 x-rays on November 8, 1895; and, whereas, natural
4 radioactivity was discovered in March of 1896 by
5 Henry Becquerel; and whereas, in the late 1890s,
6 Marie and Pierre Curie discovered the new elements
7 Polonium and Radium; and whereas, radioactive
8 materials and radiation are a useful and necessary
9 part of our world; and whereas, radiation exposure
10 can potentially be harmful to people; and whereas,
11 radiation professionals work in government,
12 industry, medical, educational, and other sectors to
13 provide expertise and serve as sources of
14 information to bring the benefits of radiation and
15 radioactivity to the public and patients, while
16 minimizing the hazards of radiation exposure.

17 And now it be resolved the Council recognizes
18 November 5th through 11th, 2023 as National
19 Radiation Professionals Week and extends its thanks
20 to all radiation professionals for their
21 contributions.

22 ALBERT TINEO: So move.

23 KATHLEEN DROTAR: Second.

24 JAMES FUTCH: What are we moving?

25 CHANTEL CORBETT: I don't know.

1 JORGE LAGUNA: The motion that you made.

2 KATHLEEN DROTAR: He can't make a motion.

3 ALBERT TINEO: The motion that you suggested
4 that we make this resolution.

5 JAMES FUTCH: Okay. All right.

6 RANDY SCHENKMAN: Okay. So we have --

7 CHANTEL CORBETT: Do we await our gifts?

8 ADAM WEAVER: It's in the mail.

9 RANDY SCHENKMAN: Does anybody have any
10 questions, discussion, anything about this?

11 CLARK ELDREDGE: Word replacement, verbiage.

12 CAMILLA GUY: I'm like, I have some edits.

13 JOSEPH DANЕК: What's kind of the outcome of
14 this? Just the fact that's it's a week?

15 JAMES FUTCH: Yeah. A lot of organizations
16 will put a poster of the notice on the wall.

17 ADAM WEAVER: Health Physics society does it.
18 A lot of them do that.

19 KATHLEEN DROTAR: It's just recognition because
20 most of the time it's -- a lot of the times, it's
21 the unrecognized. You talk about doctors, you talk
22 about nurses. And most of the people that are in
23 the profession are front line. They're first
24 person, you know. Somebody comes in with a cough,
25 and you're doing a chest x-ray. And just, you know,

1 and then it's Covid.

2 So it's just that a way of recognizing that we
3 exist and that we do significant work.

4 JOSEPH DANEK: I second the motion.

5 JAMES FUTCH: Did you want front line workers
6 to be somewhere else?

7 KATHLEEN DROTAR: Well, I think -- it was
8 recognized -- okay. So about the front line
9 workers, when Covid hit, and the testing centers,
10 the world closed down, and testing centers were only
11 allowing nurses and other front line workers to take
12 their exams. So that if you were x-ray and there's
13 a shortage of x-ray technologists across the nation
14 at this point. But that they couldn't take their
15 exam and then get certified and get licensed.

16 So ARRT stepped up and designated -- and showed
17 the, whoever that -- established that we are front
18 line workers. So I think, you know, what do you
19 think?

20 CHANTEL CORBETT: Agreed.

21 KATHLEEN DROTAR: If there's a place to put it
22 in there, it sounds okay.

23 JAMES FUTCH: I would think it would be
24 somewhat approved. How about radiation
25 professionals are front line workers in government?

1 RANDY SCHENKMAN: Yes. That sounds good.

2 JAMES FUTCH: Providing expertise?

3 CLARK ELDREDGE: Okay.

4 JAMES FUTCH: Expertise in serving.

5 CLARK ELDREDGE: Services or servicing.

6 JAMES FUTCH: As source of information is a
7 particularly bad choice of words considering it's
8 radiation, but, you know, you get the idea.

9 So we added a couple words. So that line now
10 reads, whereas radiation professionals are front
11 line workers in government, industry, medical,
12 educational and other sectors providing expertise
13 and serving as sources of information, probably
14 bringing the benefits, or to bring the benefits of
15 radiation of radioactivity to the public and
16 patients, while minimizing the hazards of radiation
17 exposure.

18 Close enough for resolution?

19 ADAM WEAVER: If you're going to -- if I'm
20 going to be a nitpicker.

21 CLARK ELDREDGE: Please. That's fine.

22 ADAM WEAVER: The Curies discovered in 1898
23 rather than the late --

24 JAMES FUTCH: Somebody -- you already checked
25 that one?

1 ADAM WEAVER: Yeah, I checked that one to make
2 sure I was right. I know it was close.

3 CHANTEL CORBETT: Wrong line.

4 ADAM WEAVER: But -- third line down.

5 CHANTEL CORBETT: There you go.

6 NICHOLAS PLAXTON: I toured Madam Curie's lab
7 last week, but it was closed.

8 ADAM WEAVER: Because of radiation?

9 NICHOLAS PLAXTON: They're closed on Sunday,
10 Monday and Tuesday.

11 JAMES FUTCH: And was it Polonium or Radium or
12 does it matter?

13 ADAM WEAVER: I think they did both of them at
14 one time.

15 KATHLEEN DROTAR: Both of them.

16 ADAM WEAVER: I don't know if they separated
17 them, but it was both of them.

18 JAMES FUTCH: I pulled this from CRCPD which --

19 NICHOLAS PLAXTON: Definitely Radium.

20 RANDY SCHENKMAN: 1890s. 1898 is 1890s.

21 CHANTEL CORBETT: It's Polonium and Radium in
22 1987.

23 ADAM WEAVER: It's nasty.

24 NICHOLAS PLAXTON: Both of them died.

25 KATHLEEN DROTAR: Polonium, yeah. The little

1 specimen that she carried around. He got run over
2 by a carriage.

3 CHANTEL CORBETT: Agreed.

4 RANDY SCHENKMAN: Any further discussion on
5 this? So is it as is written right now, approved?
6 Do we need a second?

7 JAMES FUTCH: Alberto was the motion and
8 somebody second it.

9 CHANTEL CORBETT: Joe seconded it.

10 JAMES FUTCH: Joe seconded it.

11 ALBERT TINEO: I made a motion.

12 JOSEPH DANEK: I seconded it.

13 RANDY SCHENKMAN: Okay. So all in favor, say
14 yes.

15 COUNCIL MEMBERS: Yes.

16 RANDY SCHENKMAN: Any opposed?

17 (No Response)

18 RANDY SCHENKMAN: Okay. So this resolution
19 passes.

20 KATHLEEN DROTAR: Thank you all.

21 CHANTEL CORBETT: Good job.

22 CLARK ELDREDGE: This needs to be signed by the
23 Chair and the Vice Chair.

24 JAMES FUTCH: Yeah, you've got to do that, too.

25 CLARK ELDREDGE: You've got to decide who needs

1 to sign it.

2 JAMES FUTCH: We can figure it out. We have to
3 vote on it first.

4 RANDY SCHENKMAN: We have to vote first.

5 CLARK ELDREDGE: You could decide either order,
6 decide who are the people who officially signed the
7 dock.

8 CAMILLA GUY: All three of your names could be
9 on the document. You decide whose name goes first.

10 JAMES FUTCH: That would be an administrative
11 decision. I think we'll figure it out after we get
12 a --

13 CLARK ELDREDGE: Okay.

14 JAMES FUTCH: Do you want to do yours? I'm
15 done with technology.

16 RANDY SCHENKMAN: Brenda, we're up to you.

17 BRENDA ANDREWS: Are we going to do the vote
18 now? Okay.

19 As I said earlier this morning, it's time for
20 us to nominate or decide whether or not the two
21 people who are currently in the Chair and Co-chair
22 positions, who want to continue. If we want to make
23 a motion -- which I can't make the motion. I guess
24 you guys will have to -- whether we're going to
25 continue with the Chairman and the Co-chair who are

1 currently in office, which is Randy Schenkman and
2 Mark Seddon, or if there is another person who
3 wishes to serve in that role. Wants to be
4 nominated. If you want to nominate someone, do it
5 at this time.

6 JAMES FUTCH: So we have right now, one, two,
7 three, four, five, six, seven. We've got a quorum
8 still.

9 CHANTEL CORBETT: She left.

10 JAMES FUTCH: She just left. That's good. So,
11 at this point, normally what somebody would do,
12 would suggest nominations.

13 CHANTEL CORBETT: Are there any?

14 ALBERT TINEO: Does anybody want to do it
15 because I was just going to just do a motion to --
16 for Randy and Mark to remain Chair and Co-chair.

17 KATHLEEN DROTAR: Second.

18 ADAM WEAVER: If they're willing.

19 JAMES FUTCH: So Alberto made the motion and
20 Kathy seconded.

21 ADAM WEAVER: Is that the title, Co-chair?

22 MARK SEDDON: It says Vice Chair on here.

23 ADAM WEAVER: That's the title.

24 BRENDA ANDREWS: I think it's interchangeable.

25 NICHOLAS PLAXTON: Vice-chair.

1 RANDY SCHENKMAN: Is there any discussion? Any
2 other nominations?

3 (No Response)

4 JAMES FUTCH: Nobody stepping up?

5 CHANTEL CORBETT: All agreed?

6 KATHLEEN DROTAR: Yes.

7 CHANTEL CORBETT: Any opposed?

8 (No Response)

9 CHANTEL CORBETT: There you go. Vote carries.

10 (Applause)

11 RANDY SCHENKMAN: Well, thank you all.

12 ADAM WEAVER: Another 15-year term.

13 JAMES FUTCH: Mr. Roberts is turning over in
14 his grave.

15 ADAM WEAVER: They didn't read the fine print.

16 RANDY SCHENKMAN: Okay, Brenda.

17 JAMES FUTCH: Did we tell you that's for three
18 years?

19 BRENDA ANDREWS: Yes.

20 CLARK ELDREDGE: Too late now.

21 ALBERT TINEO: By the way, that's three years.

22 BRENDA ANDREWS: Well, the only other thing I
23 wanted to talk about, and that's the new travel
24 procedures. You all have already started to
25 experience that. We started it with the last

1 authorization that had gotten approved before you
2 came to the May meeting. And when we submitted the
3 reimbursements for that travel, we were informed
4 that they were no longer taking paper travel and
5 that we had to retroactively prepare electronic
6 travel forms in our statewide travel management
7 system. Meaning, we had to put all of you in our
8 system as proxies, which is what we really wanted to
9 do in the very beginning when they did Stems, and we
10 were told that DOH was not going to do that. And
11 now they have decided, apparently it is a much more
12 efficient system than working with the paper.

13 The main thing right now is that we figure out
14 completely how you sign it and get it back to us.
15 In certain instances, it's coming back as a .pdf
16 file. In certain instances, it's being sent back to
17 us and it looks exactly like we sent it to you with
18 the signature on it. Some of them are digital
19 signatures; some of them appear to be handwritten.
20 So they're coming back to us in different ways.

21 I don't have the answer yet as to exactly how
22 you're to submit them back to us. I'm going to
23 inquire about that. I don't know if there's a
24 submit button on your end because I cannot see what
25 you see.

1 KATHLEEN DROTAR: No.

2 ALBERT TINEO: There's not.

3 BRENDA ANDREWS: There is not. Okay. I will
4 definitely find out the best way for you all to sign
5 them. You did manage to get them back to me this
6 time, so if that works, then I'm good with that. As
7 long as there's a signature on there, I'm fine.

8 But we will continue that process. To us, it's
9 actually easier for us to do it that way. Because
10 we're in Tampa every time, it's pretty repetitious
11 for most of you who are just driving for us to
12 prepare your travel and your reimbursement almost at
13 the same time.

14 Some of you still have not -- none of you have
15 been reimbursed for the last meeting. So we're
16 still working on getting those done for you, in case
17 you're wondering.

18 If you have any questions or any concerns
19 about, on your end, how to get this done, feel free
20 to give me your questions and I can put them forward
21 to our experts in that system so we can all be on
22 the same page.

23 KATHLEEN DROTAR: Brenda, the two forms came
24 across differently. The first one came across, so
25 it opened up so that you could actually put your

1 digital signature in and the second one wouldn't
2 allow you to do anything except print it off.

3 CHANTEL CORBETT: I only got one and I just
4 saved it as a .pdf and applied my signature and sent
5 it back.

6 BRENDA ANDREWS: That's why we're getting them
7 back in different ways.

8 KATHLEEN DROTAR: They're not coming out as a
9 form. They're coming out almost as a .pdf. Or if
10 you open it as a .pdf -- it opens automatically as a
11 .pdf. You can't go in or insert any text or do
12 anything like that on that last one.

13 BRENDA ANDREWS: So some of you got them as a
14 link. You clicked on the link.

15 KATHLEEN DROTAR: That's what happened.

16 BRENDA ANDREWS: Is that the better way to get
17 it? Does that link allow you to actually go in and
18 click E signature or E sign?

19 ALBERT TINEO: That's what it did for me on the
20 two forms.

21 BRENDA ANDREWS: It did that for you.

22 ALBERT TINEO: Yes.

23 CHANTEL CORBETT: I went through the link but
24 couldn't do anything.

25 KATHLEEN DROTAR: I couldn't do anything, yeah.

1 BRENDA ANDREWS: Your link didn't allow you to
2 E sign.

3 KATHLEEN DROTAR: Neither did mine.

4 CHANTEL CORBETT: But I don't know. I've got
5 Adobe Pro that I use all the time. I don't know if
6 that affects it on my end.

7 BRENDA ANDREWS: We actually have two different
8 types. My Adobe is different than the lady that's
9 working with me.

10 CHANTEL CORBETT: There's different levels. I
11 don't know if that changes on our end.

12 BRENDA ANDREWS: We'll do some tests and send
13 you forms just to test it out in the meantime so
14 that we definitely have it right for the next
15 meeting. Once we get it right, we're going to be
16 sailing because the system is a lot better than
17 doing the paper, believe me.

18 JOSEPH DANEK: Are we going to be able to edit
19 what's inside the form? We cannot edit anything in
20 the form?

21 BRENDA ANDREWS: No, you will not be able to
22 edit anything in the form. The pre-authorization is
23 more so for your authorization to travel.

24 JOSEPH DANEK: Okay.

25 BRENDA ANDREWS: And we normally figure those

1 out based on your, your habits. Either you drive in
2 the night before or you fly in the night before, the
3 morning of. We fill those out based on that because
4 we're meeting here in Tampa every time now, so it's
5 pretty repetitious. So for us, when we do fill
6 those out, unless we have -- if we don't have
7 updated information, you will need to just call us
8 and tell us that I've moved. This is my new address
9 and whatever. And then we can go back in and update
10 it and resend it to you. And we will be sending
11 these out in time so that we have -- we'll be able
12 believe to work out everything.

13 In the meantime, if there's something not right
14 on the pre-authorization, most times you don't have
15 to worry about it because that's only to get you
16 approval. When you get your reimbursement, if there
17 is something that was on there that you did not do,
18 like if you didn't stay overnight -- like Joe, we
19 always put his for overnight, but this time, he did
20 not come in and stay overnight. Although his
21 authorization says that right now, when we do his
22 reimbursement, it will be one day. So it gets
23 corrected on the back end. And then you'll sign
24 that and say, this is what I actually did.

25 Same with, you know, somebody stays overnight

1 and we have you coming in the day of the meeting,
2 it's the reverse. You will be given the correct
3 amount of reimbursement by staying overnight. So it
4 works both ways.

5 CLARK ELDREDGE: We would probably have to redo
6 those because the system -- in your approval, it
7 will not reimburse you for any day before the
8 approval. So if you said they were driving in in
9 the morning, and they came in the day before, we
10 might have to resubmit that and get it approved
11 after the fact because the system won't let you put
12 in starting travel before.

13 BRENDA ANDREWS: Okay. That's the electronic
14 way. Otherwise, with the paper, we were able to
15 just do the paper reimbursement based on what you
16 did. So that's a good point, Clark.

17 That means we would have to send it back to you
18 for that signature again. And what we will do is
19 attach the one that was originally signed to show
20 that you signed one in the beginning, because that
21 has to go out first. And then if it changes, then
22 we will send you the new one, have that one signed
23 and attach all of that together. They just need to
24 make sure they have a clear paper trail of what is
25 going on.

1 RANDY SCHENKMAN: Do we still have to give you
2 the cost of everything that we have?

3 BRENDA ANDREWS: That's a good question. The
4 State will reimburse -- if you stay overnight and
5 you have a hotel receipt, we need the hotel receipt.
6 Meals, and those types of things, are already
7 pre-determined based on the State rate. So there is
8 no need to give us meal receipts because that
9 reimbursement is already set.

10 If you have other kinds of receipts, like
11 parking at the airport, or tolls or something like
12 that, we do --

13 RANDY SCHENKMAN: Or air fare.

14 BRENDA ANDREWS: Definitely air fare, we need
15 those receipts. You can just e-mail them back to me
16 and we attach those to your reimbursement.

17 Any other questions? Once we get used to this
18 system, it's going to be really nice. It's not like
19 the system we had before where you all had to go in
20 and do your travel. That gave people nightmares.
21 This puts it all on us to fill everything out. And
22 you all, the only thing you have to do is look it
23 over and sign.

24 And if we have a pre-authorization that is not
25 correct, feel free to e-mail us back and say I'm not

1 doing that; this is what I'm doing, and we can fix
2 it at that point. It makes it a lot easier. So
3 that's it for me.

4 CHANTEL CORBETT: Do we need to do the next
5 meeting?

6 RANDY SCHENKMAN: Is there any other business?
7 Anything anybody else wants to discuss before we
8 figure out our next meeting?

9 MARK SEDDON: I have a request that the next
10 meeting we agree is the speech-language pathologist
11 discussion. I think we talked about it a couple
12 meetings ago. I think it's not been discussed.

13 RANDY SCHENKMAN: Okay. Can we make that a
14 topic?

15 JAMES FUTCH: Mm-hmm.

16 RANDY SCHENKMAN: Okay.

17 KATHLEEN DROTAR: I'm sorry. At the last
18 meeting, we had Dontavia from MqA. And just to
19 report back to the Council, that the things that we
20 talked about with licensing for new technologists,
21 it still has not been fixed.

22 RANDY SCHENKMAN: That's unfortunate.

23 KATHLEEN DROTAR: It's very unfortunate because
24 people aren't being able to -- they have jobs and
25 they can't work because of the lag time.

1 MARK SEDDON: What's the current lag time
2 sitting at?

3 JAMES FUTCH: I would be happy to tell you but
4 I was given no stats or no figures, although those
5 were requested.

6 KATHLEEN DROTAR: It's over a month.

7 CHANTEL CORBETT: Yeah. I was going to say, we
8 had a nuclear technologist come from out of state,
9 he'd been a tech for over 20 years. When he called
10 the State, he asked about what he needed to work in
11 Florida. He was told only ARRT, which was a problem
12 because I think they meant to get your license, you
13 only need ARRT. But, yes. So he thought he could
14 work with just the ARRT. So he -- obviously, once
15 we found that out, we told him, no. You have to be
16 licensed.

17 He went online that day and we're still waiting
18 on that license and that was August 1st.

19 KATHLEEN DROTAR: Yeah. And temporary
20 licenses, I've told my students, my graduates, don't
21 even bother with the temporary license because they
22 take the registry so soon after they graduate, that
23 by the time the temporary would be processed, they
24 already have their, they already have their
25 certificate from the ARRT.

1 And then some people have been told that they
2 have to pay another additional fee to have that
3 changed over and in days before. And then I was
4 told by the department that that isn't true. That
5 they should only be paying the one fee.

6 But it's just a real bollox because they're
7 waiting and waiting.

8 JAMES FUTCH: The -- we have weekly meetings
9 with Melanie; occasionally with Dontavia, and they
10 requested that we not have those because they've
11 been given a project by the Bureau Chief. I suspect
12 it might be catch up on licensing, but that's just a
13 guess. So we haven't had a weekly meeting in a
14 couple weeks. We can -- what I hear you saying is
15 you would like to talk to someone from MqA?

16 KATHLEEN DROTAR: It doesn't seem to do much
17 good, but I'd be happy to speak with anyone that
18 might be able to move things forward because it's,
19 it's not -- it's statewide. It's affecting new
20 people. Renewals come out pretty quickly, but that
21 seems to -- that hasn't been tampered with.

22 JAMES FUTCH: Renewals are handled by a
23 different part of MqA.

24 CHANTEL CORBETT: Just to clarify, also, the
25 State is still issuing paper licenses or that is

1 stopped as of when?

2 JAMES FUTCH: July. What they said was as of
3 July 1st, they were not going to print the paper
4 licenses anymore.

5 CHANTEL CORBETT: That's what I thought.

6 JAMES FUTCH: What you have in your renewal
7 account with the place that you go for MqA --

8 KATHLEEN DROTAR: Right.

9 JAMES FUTCH: -- to fill out the renewal
10 application. In there, they were going to put the
11 .pdf of what they used to mail. And that's what
12 your -- so it's under your control still at opposed
13 to the .pdf, that whole certificate.

14 CHANTEL CORBETT: Will it be satisfactory to
15 print off the verification page for posting at their
16 locations?

17 JAMES FUTCH: For --

18 KATHLEEN DROTAR: Because we're supposed to
19 post our licenses.

20 CLARK ELDREDGE: There is a .pdf license in the
21 system to print.

22 RANDY SCHENKMAN: You have to print it,
23 yourself.

24 CLARK ELDREDGE: To print your own, print
25 yourself your certificate.

1 CHANTEL CORBETT: I understand that. That's
2 not the question. So can they post just the
3 verification page from, like, the MqA site, saying
4 if you look up a licensee, it says like, this is
5 your name, this is what you're licensed as, this is
6 when you expire. Is that satisfactory for
7 inspection purposes?

8 CLARK ELDREDGE: Printing off their license and
9 posting it is what would be required, according to
10 our codes.

11 CHANTEL CORBETT: Okay. So they do need to
12 have a .pdf of the actual license. Okay.

13 CLARK ELDREDGE: Right.

14 CHANTEL CORBETT: We had that problem where a
15 lot of people said, well, I'm not getting a paper
16 license. They didn't know they could go in and
17 print that. We had them print the verification
18 because that's all we could come up with because we
19 didn't know that was available.

20 CLARK ELDREDGE: It's supposed to be there.

21 KATHLEEN DROTAR: Yeah, it prints out. You can
22 go in to verify and it will, and it will print out.
23 That's easy.

24 CHANTEL CORBETT: The person, themselves, has
25 to go in.

1 KATHLEEN DROTAR: No, they don't. Anybody can
2 go in because it's open because the State licensing
3 is --

4 CHANTEL CORBETT: No, no. I can go in and
5 verify somebody's license --

6 KATHLEEN DROTAR: For verification.

7 CHANTEL CORBETT: They're saying you have to
8 have --

9 CLARK ELDREDGE: They have to log into their
10 own account.

11 JAMES FUTCH: So let's read what the law says.

12 CLARK ELDREDGE: Okay.

13 KATHLEEN DROTAR: Thank you, because I would've
14 been printing out the other.

15 CHANTEL CORBETT: Right. That's what we been
16 doing because we didn't know any different.

17 JAMES FUTCH: So this is 468307. This is in
18 the Rad Tech section of the statutes. It says
19 certificate issuance display. And it's this line
20 right here. Can you all read that? That's what I
21 get for zooming in too far. I'll zoom it a
22 different way.

23 KATHLEEN DROTAR: Which one? Every employer of
24 certification holders? Is that it?

25 JAMES FUTCH: This time I can scroll. Hold on.

1 Bear with me. There you go.

2 KATHLEEN DROTAR: Every employer certificate
3 holder shall display the certificates.

4 CHANTEL CORBETT: Like we've been mailed in the
5 past.

6 KEVIN KUNDER: Yes.

7 CHANTEL CORBETT: The only people who can
8 access that is the actual employee.

9 RANDY SCHENKMAN: Right.

10 JAMES FUTCH: That's supposed to be the case.
11 I haven't seen it, myself.

12 KATHLEEN DROTAR: Then I don't know.

13 JAMES FUTCH: Have you found it in your
14 account? Has anybody renewed yet?

15 KATHLEEN DROTAR: That I haven't done. No, not
16 until January.

17 CHANTEL CORBETT: I'm getting ready to. I
18 haven't yet.

19 JAMES FUTCH: I haven't had any staff who have
20 done it yet.

21 KATHLEEN DROTAR: I have somebody who renews
22 next month.

23 JAMES FUTCH: Geo is just like a month before.
24 She was close, like June before.

25 KENNETH BARNHART: Can they only print it off

1 once?

2 JAMES FUTCH: No, no. I haven't seen it, but
3 it's a .pdf.

4 CHANTEL CORBETT: Ideally, if we can link that
5 somehow to the publication page. The problem with
6 that, a lot of them have their home addresses on it,
7 which is probably why it's not. Yeah, that's going
8 to take some catch up, just FYI.

9 KENNETH BARNHART: They only have the one copy.

10 CHANTEL CORBETT: Right. If we can print it
11 out and e-mail it or whatever. I'm saying right
12 now, a lot of the locations don't know that that's
13 available. And so we had to print the online
14 verification because that's all we had. So I'm just
15 worried that --

16 RANDY SCHENKMAN: But the person, themselves,
17 should be able to print it out and give it to you.

18 CHANTEL CORBETT: I'm aware now. But what I'm
19 saying, until now, I didn't even know that was an
20 option.

21 RANDY SCHENKMAN: I see.

22 CHANTEL CORBETT: With 200 clients, we have
23 hospitals posting the online verification page.

24 JAMES FUTCH: Somewhere in the voluminous
25 verification pages, they have got a notice about

1 this. I don't remember where it is.

2 KATHLEEN DROTAR: There was an e-mail that was
3 sent out.

4 CHANTEL CORBETT: Oh, no, that doesn't help.

5 JAMES FUTCH: We're in the same boat. I can't
6 see what you guys see. We've talked about this
7 before. We'd love to see what the wording is on
8 that application.

9 CHANTEL CORBETT: Yours worked?

10 ALBERT TINEO: I just did it, yeah. So there
11 is an Adobe Reader link that you hit.

12 JAMES FUTCH: You went into your account.

13 CHANTEL CORBETT: Okay. Good. You can see the
14 actual license?

15 ALBERT TINEO: Your license, yeah.

16 CHANTEL CORBETT: Yeah. Okay.

17 JAMES FUTCH: You can save it and download it.

18 ALBERT TINEO: I didn't even know that we
19 needed to do that.

20 CHANTEL CORBETT: I do that all day every day.
21 I didn't know that --

22 KATHLEEN DROTAR: You didn't know?

23 CHANTEL CORBETT: I didn't know.

24 JAMES FUTCH: Everybody that has a license is
25 going to your account and checking it out right now.

1 CHANTEL CORBETT: Just FYI.

2 JAMES FUTCH: I know I have my license here.

3 It's my license. They better give it to me.

4 CHANTEL CORBETT: Just trying to keep people
5 from being excited.

6 KATHLEEN DROTAR: That was useful information.

7 JAMES FUTCH: Didn't ARRT just do this?

8 KATHLEEN DROTAR: What?

9 ALBERT TINEO: Yeah, the ARRT.

10 KATHLEEN DROTAR: That was a couple years ago.

11 CHANTEL CORBETT: Honestly, nobody in Florida,
12 the license trumps it, so everybody --

13 KATHLEEN DROTAR: ARRT is one-stop shopping so
14 you can go on into the website -- Chantel was
15 saying, you can go on and do a verification and you
16 can do a print and then you have --

17 CHANTEL CORBETT: They accept that page as
18 their, okay. They don't have an actual picture of a
19 card anymore.

20 JAMES FUTCH: Yeah.

21 CHANTEL CORBETT: Okay. Thank you guys.

22 JAMES FUTCH: We tell our staff, because we can
23 go up there and do it, too. Do it with the Social.
24 Because there's a lot of very similarly named people
25 out there.

1 CHANTEL CORBETT: That's true.

2 JAMES FUTCH: And you can't see on the backside
3 of it, how it was generated. So go in and do it
4 with a Social, because we have that. We've got your
5 application that's got everything.

6 KATHLEEN DROTAR: Yeah.

7 JAMES FUTCH: That ought to be confusing to
8 read, though.

9 CHANTEL CORBETT: All right. So May date.
10 Sorry.

11 RANDY SCHENKMAN: Okay. Our next meeting.

12 CHANTEL CORBETT: FNMT is the 16th through the
13 20th.

14 CLARK ELDREDGE: I will tell you right now that
15 the Bureau --

16 JAMES FUTCH: CRCPD?

17 CLARK ELDREDGE: Yeah, the CRCPD, the 16th
18 through the 24th are blocked out for BRC.

19 RANDY SCHENKMAN: That's May.

20 JAMES FUTCH: That dovetails with yours.

21 CHANTEL CORBETT: That's the same time.

22 JAMES FUTCH: Any other societies? Anybody
23 going to FSRT?

24 KATHLEEN DROTAR: No. No.

25 JAMES FUTCH: SFRT.

1 KATHLEEN DROTAR: No. We're doing April, so
2 it's okay. And ASRT is in Orlando, but that's in
3 June.

4 CHANTEL CORBETT: Mother's Day is the 12th.

5 JAMES FUTCH: The 7th or the 9th. Maybe if you
6 want to stay in front of all that out of all those
7 weeks?

8 RANDY SCHENKMAN: Does anybody have a
9 preference?

10 CAMILLA GUY: The 9th.

11 RANDY SCHENKMAN: You like the 9th?

12 CAMILLA GUY: Yeah.

13 ALBERT TINEO: The 7th sounds good.

14 KATHLEEN DROTAR: Not the 7th.

15 CAMILLA GUY: The 6th is my birthday.

16 RANDY SCHENKMAN: She won't be able to be here
17 the 7th. So is the 9th good for everybody?

18 KATHLEEN DROTAR: The 9th?

19 JOSEPH DANEK: The 9th.

20 RANDY SCHENKMAN: Okay. Let's make it for the
21 9th.

22 KATHLEEN DROTAR: It's a Thursday.

23 RANDY SCHENKMAN: Her birthday is the 6th.

24 ALBERT TINEO: Move to adjourn.

25 JAMES FUTCH: Are we adjourning while we have a

1 quorum?

2 RANDY SCHENKMAN: Before anybody leaves, is
3 there anything else that is -- is there a problem
4 with the 9th?

5 BRENDA ANDREWS: No, not for me.

6 RANDY SCHENKMAN: Okay. So let's do that. And
7 will somebody make a motion to adjourn?

8 ALBERT TINEO: So move.

9 KATHLEEN DROTAR: Second.

10 ADAM WEAVER: See you in May.

11 RANDY SCHENKMAN: Okay. We are now adjourned.

12 Thank you all.

13 (Proceedings concluded at 3:06 p.m.)

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1 CERTIFICATE OF REPORTER

2 STATE OF FLORIDA:

3 COUNTY OF ORANGE:

4

5 I, RITA G. MEYER, RDR, CRR, CRC, do hereby certify
6 that I was authorized to and did stenographically report
7 the foregoing proceedings and that the foregoing
8 transcript is a true and correct record of my
9 stenographic notes.

10 I FURTHER CERTIFY that I am not a relative,
11 employee, attorney or counsel of any of the parties, nor
12 am I a relative or employee of any of the parties,
13 attorneys or counsel connected with the action, nor am I
14 financially interested in the outcome of the action.

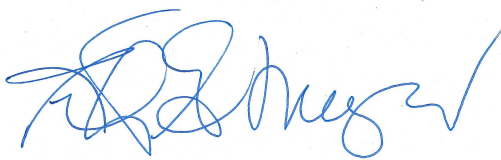
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DATED this 5th day of October, 2023.

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RITA G. MEYER, RDR, CRR, CRC

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	BRENDA	102/4 105/10	6/13 9/1 9/15	135/10 137/2
ADAM	ANDREWS:	114/23 115/2	9/17 10/20	137/4 137/20
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			[18] 5/22	

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SCHENKMA	161/10	11 [5] 48/10	109/24	61/6 61/7
N: [72] 3/2	161/15	54/19 75/4	160/12	65/13 74/12
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