Regulations, and Variances, Mine Safety and Health Administration, 1100 Wilson Boulevard, Room 2352, Arlington, Virginia 22209. All comments must be postmarked or received in that office on or before April 2, 2003. Copies of these petitions are available for inspection at that address.

Dated at Arlington, Virginia, this 25th day of February, 2003.

Marvin W. Nichols, Jr.,

Director, Office of Standards, Regulations, and Variances.

[FR Doc. 03–4860 Filed 2–28–03; 8:45 am]

BILLING CODE 4510–43–P

NATIONAL SCIENCE FOUNDATION

Sunshine Act Meeting Notice

AGENCY HOLDING MEETING: National Science Foundation, National Science Board, Task Force on National Workforce Policies for Science & Engineering.

DATE AND TIME: March 3, 2003, 12 p.m.–1 p.m.; Open session.

PLACE: The National Science Foundation, Stafford One Building, 4201 Wilson Boulevard, Room 120, Arlington, VA 22230.

STATUS: This meeting will be open to the public.

MATTERS TO BE CONSIDERED: Monday, March 3, 2003; open session.

Open Session (12 p.m. to 1 p.m.)

—Discussion of comments on the draft report of the NSB/EHR Task Force on National Workforce Policies for S&E.

FOR FURTHER INFORMATION CONTACT: Gerard Glaser, Executive Officer, NSB, (703) 292–7000, *http://www.nsf.gov/nsb.*

Gerard Glaser,

Executive Officer.

[FR Doc. 03–5007 Filed 2–27–03; 12:17 pm]

BILLING CODE 7555–01–M

NUCLEAR REGULATORY COMMISSION

[Docket No. 030–35594, License No. 37–30603–01, EA No. 02–072]

In the Matter of Advance Medical Imaging and Nuclear Services, Easton, PA; Order Imposing a Civil Monetary Penalty

I

Advanced Medical Imaging and Nuclear Services (Licensee) is the holder of Byproduct Materials License No. 37–30603–01 (License) issued by the Nuclear Regulatory Commission (NRC or Commission) pursuant to 10 CFR parts 30 and 35. The License authorizes the Licensee to possess and use certain byproduct materials (identified in 10 CFR 35.100 and 35.200) at its Easton, Pennsylvania facility for any uptake, excretion, imaging, and localization procedures approved in those parts. The license was issued on February 16, 2001, and is due to expire on February 28, 2011.

II

An inspection of the Licensee's activities was conducted on November 30, 2001, at the Licensee's facility located in Easton, Pennsylvania. Further, an investigation was also conducted by the NRC Office of Investigations. The results of this inspection and investigation indicated that the Licensee had not conducted its activities in full compliance with NRC requirements. A written notice of violation and proposed imposition of civil penalty (notice) was served upon the Licensee by letter dated October 22, 2002. The notice stated the nature of the violations, the provisions of the NRC's requirements that the Licensee had violated, and the amount of the civil penalty proposed for the violations.

The Licensee responded to the notice, in a letter, dated November 21, 2002. In its response, the Licensee: (1) Admits the first of three violations that were classified as a Severity Level II problem; (2) denies the other two violations that were part of the Severity Level II problem; (3) contests the Severity Level II classification for the three violations; (4) contests the amount of the civil penalty for the Severity Level II problem; and (5) admits two other violations that were classified at Severity Level IV.

III

After consideration of the Licensee's response and the statements of fact, explanation, and argument contained therein, the NRC staff has determined, as set forth in the Appendix to this Order, that an adequate basis was not provided for withdrawal of any violations, for reduction of the Severity Level II classification, or for reduction or withdrawal of the penalty. Therefore, the NRC staff has determined that a penalty of $43,200 should be imposed.

IV

In view of the foregoing and pursuant to section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205, *it is hereby ordered that:*

The Licensee pay a civil penalty in the amount of $43,200 within 30 days of the date of this Order, in accordance with NUREG/BR–0254. In addition, at the time of making the payment, the licensee shall submit a statement indicating when and by what method payment was made, to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852–2738.

V

The Licensee may request a hearing within 30 days of the date of this Order. Where good cause is shown, consideration will be given to extending the time to request a hearing. A request for extension of time must be made in writing to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555, and include a statement of good cause for the extension. A request for a hearing should be clearly marked as a ''Request for an Enforcement Hearing'' and shall be addressed to the Secretary, U.S. Nuclear Regulatory Commission, ATTN: Rulemakings and Adjudications Staff, Washington, DC 20555. Copies also shall be sent to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555, to the Assistant General Counsel for Materials Litigation and Enforcement at the same address, and to the Regional Administrator, NRC Region I, 475 Allendale Road, King of Prussia, PA 19406. Because of continuing disruptions in delivery of mail to United States Government offices, it is requested that requests for hearing be transmitted to the Secretary of the Commission either by means of facsimile transmission to 301–415–1101 or by e-mail to *hearingdocket@nrc.gov* and also to the Office of the General Counsel either by means of facsimile transmission to 301–415–3725 or by e-mail to *OGCMailCenter@nrc.gov.*

If a hearing is requested, the Commission will issue an Order designating the time and place of the hearing. If the Licensee fails to request a hearing within 30 days of the date of this Order, the provisions of this Order shall be effective without further proceedings. If payment has not been made by that time, the matter may be referred to the Attorney General for collection.

In the event the Licensee requests a hearing as provided above, the issues to be considered at such hearing shall be:

(a) Whether the Licensee was in violation of the Commission's requirements as set forth in Violations B and C of the notice referenced in section II above, and

(b) Whether, on the basis of such violations, and the additional violations

set forth in the notice of violation that the Licensee admitted, this Order should be sustained.

Dated in Rockville, Maryland, this 19th day of February, 2003.

For the Nuclear Regulatory Commission.

Carl J. Paperiello,

Deputy Executive Director for Materials, Research and State Programs.

Appendix

Evaluations and Conclusion

On October 22, 2002, a notice of violation and proposed imposition of civil penalty (notice) was issued for violations identified during an NRC inspection conducted at the Licensee's facility located in Easton, Pennsylvania. The penalty was issued for three violations that were classified as a Severity Level II problem. The Licensee responded to the notice in a letter, dated November 21, 2002. In its response, the Licensee: (1) Admits the first of the three violations that were classified as a Severity Level II problem; (2) denies the other two violations that were part of the Severity Level II problem; (3) contests the Severity Level II classification for the three violations; (4) contests the amount of the civil penalty for the Severity Level II problem; and, (5) admits two other violations that were classified at Severity Level IV. The NRC's evaluation and conclusion regarding the Licensee's request is as follows:

1. Restatement of the Three Violations Classified at Severity Level II and Assessed a Civil Penalty

A. 10 CFR 35.11 requires, in part, that a person shall not use byproduct material for medical use except in accordance with a specific license or under the supervision of an authorized user as provided in 10 CFR 35.25.

Contrary to the above, from June 2001 to November 30, 2001, a Nuclear Medicine Technologist (NMT) used byproduct material for patient diagnosis on approximately 590 occasions, and the use by the NMT was not in accordance with a specific license. In addition, the NMT was not under the supervision of an authorized user.

B. 10 CFR 35.21(a) requires that a licensee shall appoint a Radiation Safety Officer responsible for implementing the radiation safety program. The licensee, through the Radiation Safety Officer, shall ensure that radiation safety activities are being performed in accordance with approved procedures and regulatory requirements in daily operation of the licensee's byproduct material program.

Contrary to the above, from about March 2001 to November 30, 2001, the licensee conducted licensed activities, including ordering and administering radiopharmaceuticals on approximately 590 occasions, and during that time, the licensee had not appointed a Radiation Safety Officer responsible for implementing the radiation safety program, to ensure that activities were being performed in accordance with approved procedures and regulatory requirements in daily operations of the licensee's program.

C. 10 CFR 30.9(a) requires, in part, that information required by license conditions to be maintained by the licensee, shall be complete and accurate in all material respects.

License condition 15.A of the NRC license for AMINS requires that the licensee conduct its program in accordance with the statements, representations, and procedures contained in various documents, including the license application dated October 20, 2000.

Item 10, Attachment 10.6 of the NRC license application for AMINS dated October 20, 2000, requires that written records will be made that identify the Authorized User when ordering radioactive materials.

Contrary to the above, on November 30, 2001, information required to be maintained by the licensee was not complete and accurate in all material respects. Specifically, all records of radioactive materials ordered between March 2001 and November 2001 indicated that the Authorized User who ordered the radiopharmaceuticals was Dr. Brij Mohan Gupta (Dr. Mohan). These records were not accurate in that Dr. Mohan was not employed by the licensee as an Authorized User, nor did he function in that capacity. This statement was material because an Authorized User was required by the license and by NRC regulations for supervision of the administration of radiopharmaceuticals to patients.

These violations represent a Severity Level II problem (Supplement IV). Civil Penalty—$43,200

2. Summary of Licensee's Response Denying Violation 1.B

The licensee denies Violation 1.B, involving the licensee not appointing an RSO responsible for implementing the program when the radiopharmaceuticals were ordered and administered on the approximately 590 occasions. The licensee contends that with the assistance of its consultant, it was able to assure regulatory requirements were met during daily operations of the facility.

NRC Evaluation of Licensee's Response Denying Violation 1.B

Although the licensee denies this violation, the licensee, in its response, admits that it was unable to finalize arrangements with the individual who was listed on its license as the RSO. Therefore, since such arrangements were never finalized, and since the individual listed as the RSO never served as the licensee's RSO, the licensee did not appoint an RSO, consistent with requirements, responsible for implementing the radiation safety program. Rather, the license identified an individual as the RSO who was not employed by the licensee either directly, or as a contractor or consultant, and who did not implement the radiation safety program at any time, including between March 2001 and November 30, 2001, when the radiopharmaceuticals were ordered and administered on the approximately 590 occasions. Therefore, even though the licensee indicates that it was able to assure, as evidenced by a subsequent review by its consultant, that other regulatory requirements had been met during daily operations of the facility, the licensee did not provide an adequate basis for the NRC to withdraw Violation 1.B in the notice. Accordingly, the violation remains as stated in the notice.

3. Summary of Licensee's Response Denying Violation 1.C

The licensee denies Violation 1.C involving the creation of inaccurate records of the radioactive materials ordered on the 590 occasions. The records were considered inaccurate in that the licensee listed as the authorized user an individual physician who was not employed by the licensee and was not performing the duties of the authorized user. The licensee denies this violation because the physician was identified on the license as the AU, and the records were completed in a manner consistent with the license. The licensee states that it was not aware of any regulatory requirement that the authorized user be employed by the licensee.

NRC Evaluation of Licensee's Response Denying Violation 1.C

The NRC had determined that Violation 1.C occurred because information required to be maintained by the licensee was not complete and accurate in all material respects. Specifically, all records of radioactive materials ordered between March 2001 and November 2001 indicated that the Authorized User who ordered the radiopharmaceuticals was Dr. Brij Mohan Gupta (Dr. Mohan). These records were not accurate in that Dr. Mohan was not employed by the licensee, nor acting in any capacity, as an Authorized User.

In denying this violation, the licensee states that the crux of this regulatory requirement is that the licensee's records be accurate, and that the performance by the AU of his/her obligations is not the focus of this regulation but is covered under other regulations. The NRC maintains that these records were not accurate because the individual listed in the records as the AU was never employed by the licensee, nor did that individual otherwise serve or act as the AU (such as via a contractor or consultant arrangement). Therefore, the licensee did not provide an adequate basis for the NRC to withdraw Violation 1.C in the notice. Accordingly, the violation remains as stated in the notice.

4. Summary of Licensee's Response Contesting Classification of the Three Violations at Severity Level II

The licensee contests the Severity Level II problem classification for the three violations set forth in section I of the notice. The licensee contends that the violations were not willful; the VP and COO have been penalized; even if the VP and COO's actions were willful, the action taken against them obviates the need for substantial penalties to the licensee; there were no actual or realistic potential safety consequences as a result of the violations; and classification of the violations at a Level II is inconsistent with NRC policy and prior determinations. With respect to the last point, the licensee indicates that the seven examples of Severity Level II described in the HP supplement of the enforcement policy, relate to overexposures or unauthorized releases.

Further, the licensee provided a list of 16 other Severity Level III enforcement actions that the licensee maintains are similar to its case.

NRC Evaluation of Licensee's Response Contesting Classification of the Three Violations at Severity Level II

In assessing the significance of violations, and assigning an appropriate Severity Level, the NRC considers the actual and potential consequences of the violations, their impact on the regulatory process, and any willful aspects of the violations, as noted in section IV.A of the NRC enforcement policy (NUREG–1600). The supplements to the enforcement policy provide examples of different Severity Levels and serve as guidance in determining the appropriate Severity Level for the violations, as noted in section IV.B of the enforcement policy. In this case, since the violations included the failure to have an AU and RSO, the violations would normally have been classified at Severity Level III in accordance with section C.8 of Supplement VI of the enforcement policy. However, section IV.A.4 of the enforcement policy specifies that violations may be considered more significant if they include indications of willfulness. In deciding whether to increase the significance of the violations, the NRC considers the positions and responsibilities of the persons involved, the significance of the underlying violations, the intent of the violators, and the economic advantage gained.

In this case, the NRC maintains that the violations were deliberate, notwithstanding the licensee's denial. As noted in the NRC October 22, 2002, letter transmitting the notice of violation and proposed imposition of civil penalty, the NRC considered the following facts in concluding that the violations were deliberate: (1) The VP prepared the NRC license application in October 2000, with the aid of a consulting physicist, and he listed an individual (a physician) as the AU and RSO on the application; however, the named individual was never employed by AMINS and never performed the duties of the AU or RSO at AMINS; (2) from June 2001 through November 2001, AMINS staff listed that individual as the AU of record when it ordered and administered radiopharmaceuticals on approximately 590 occasions; (3) in October 2001, a consulting physicist conducted an audit that revealed that the duties of the AU/RSO had not been performed, and he briefed the licensee regarding the problem at the end of the audit, yet NRC licensed activities continued until the NRC inspection on November 30, 2001; (4) the VP, when interviewed by an OI investigator, admitted that he knew the facility was required to have an AU and RSO and knew as early as June 2001 that not having an AU and RSO was a problem, but he did not take action to correct the situation; and (5) both the VP and COO admitted to the OI investigator that there were financial considerations associated with keeping the facility open.

Furthermore, the violations were the result of the actions by senior individuals in the organization (namely a Vice President and the Chief Operating Officer), and there was an economic advantage to the licensee when it performed 590 administrations of radioactive materials at a time when it did not have an RSO and AU. Accordingly, even though there were no safety consequences identified from these violations, and actions were taken against both the Vice President and Chief Operating Officer, by both the licensee and the NRC, the NRC maintains that it was appropriate to increase the Severity Level classification from a Severity Level III to a Severity Level II in this case, and that such an increase is consistent with NRC policy and past determinations. In addition, contrary to the licensee's assertion, the 16 enforcement actions listed in the licensee's response are not similar to the circumstances of the AMINS enforcement action. Only six involved medical or human uses, and each of those six only involved one or two incidents of regulatory violations.

5. Summary of Licensee's Response Contesting the Amount of the Civil Penalty and Requesting Withdrawal or Reduction of the Civil Penalty

The licensee contests the amount of the civil penalty, contending that the NRC has abused its discretion by proposing a civil penalty of $43,200. In support of that contention, the licensee reiterates that it denies two of the three violations that were classified as the Severity Level II problem. In addition, the licensee maintains that it should be given credit for notification, asserting that the COO and VP voluntarily informed the inspector of the violations. Also, the licensee stated that even if it is not entitled to credit for identification, the violations should be classified at Severity Level III and the penalty should not exceed the base amount of $3000 for a Severity Level III. Finally, the licensee states that the use of weekly civil penalties was not warranted and was inconsistent with prior NRC cases, and cited examples of prior enforcement actions that the licensee believes to be inconsistent with the action taken against the licensee.

NRC Evaluation of Licensee's Response Contesting the Amount of the Civil Penalty and Requesting Withdrawal or Reduction of the Civil Penalty

The NRC disagrees that it has abused its discretion in determining the amount of the civil penalty in this case. For the reasons set forth in sections 3 and 4 above, the NRC maintains that all three violations occurred as stated in the notice, and were appropriately classified as a Severity Level II problem.

In addition, the NRC also maintains that the licensee is not entitled to credit for identification because the violations were identified by the NRC when the inspector arrived at the site on November 30, 2001. The NRC was not informed of such violations prior to that inspection, nor were there any indications in licensee's records identifying the violations. During that inspection, the NRC learned that the licensee's consulting physicist had identified the failure to have an AU during an audit, and briefed the licensee regarding the problem on October 3, 2001.

Finally, as noted in the October 22, 2002, letter transmitting the notice of violation and proposed imposition of civil penalty, the NRC decided that consideration of daily civil penalties was appropriate in this case, due to the multiple instances of deliberately ordering and administering byproduct material to human patients without the benefit of a physician authorized user and a radiation safety officer, the level of management involved, the economic benefit associated with continuing to operate without an AU and RSO, and the failure to correct the problem even after the findings of the licensee's consultant on October 3, 2001. The NRC has also reviewed the enforcement cases referenced by the licensee, and finds that the circumstances in this case are not similar to any of the cases cited. Accordingly, the NRC maintains that it is appropriate to issue: (1) A base civil penalty amount of $4,800 for the occurrence of the violations between March 2001 and October 3, 2001; and (2) additional civil penalty in the base amount of $4,800 for each of the eight weeks that the violations continued even after the consultant identified the problem to the licensee on October 3, 2001. Therefore, the licensee has not provided an adequate basis to withdraw or reduce that civil penalty.

6. NRC Conclusion

The NRC has concluded that the Licensee did not provide an adequate basis for withdrawal of any of the violations, or for withdrawal or reduction of the civil penalty amount. Accordingly, the proposed civil penalty in the amount of $43,200 should be imposed.

[FR Doc. 03–4891 Filed 2–28–03; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

Application for a License To Export a Utilization Facility

Pursuant to 10 CFR 110.70(b)(1) ''Public notice of receipt of an application,'' please take notice that the Nuclear Regulatory Commission has received the following request for an export license. Copies of the request are available electronically through ADAMS and can be accessed through the Public Electronic Reading Room (PERR) link <*http://www.nrc.gov/NRC/ADAMS/index.html*> at the NRC Homepage.

A request for a hearing or petition for leave to intervene may be filed within 30 days after publication of this notice in the **Federal Register**. Any request for hearing or petition for leave to intervene shall be served by the requestor or petitioner upon the applicant, the Office of the General Counsel, U.S. Nuclear Regulatory Commission, Washington, DC 20555; the Secretary, U.S. Nuclear Regulatory Commission, Washington, DC 20555; and the Executive Secretary, U.S. Department of State, Washington, DC 20520.

In its review of the application for a license to export a utilization facility as