# CHECK LIST FOR COMISSIONING OF NUCLEAR MEDICINE FACILITIES

**Date:**

## Details of the Institute:

Institution number in eLORA: **UP – xxxxxx - INST**

Name and address of the Institute: xxxxxxxxxxxxxxxxx

**xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx**

**xxxxxxxxxxxxxxxxxxx**

**TEL – xxxxx – xxxxxxxxxxx**

1. **Type of the facility:** Govt/Semi-Govt/Autonomous/Private/Jointventure/Others: **PRIVATE**

## Employer:

* 1. Name : **MR. xxxxxxxxxxxx**
  2. Designation : **xxxxxxxxxxxxxxx**
  3. Phone no. : **xxxxxxxxxxxx**

## Licensee:

* 1. Name : **SAME AS EMLOYER**
  2. Designation
  3. Phoneno.

## RSO(II/III):

* 1. Name : **xxxxxxxxx**
  2. Designation : **xxxxxxxxxxxxx**

* 1. Phone no. : **xxxxxxxxxxxxx**

## Verification of approvals issued

* 1. Weather the facility has been constructed as per theapprovedplan **Yes**/~~N~~o
  2. Layout approval available: **Yes**/~~No~~

If yes, provide document no here:

* 1. Whether RSO certificate is valid: **Yes**/~~No~~

If yes, provide document no here:

# Sources/Facilitiesavailable

* 1. Procedures carried out: In-vitro assay



In-vivo non-imaging In-vivo imaging Low Dose Therapy High DoseTherapy

Any other procedures carried out, please specify:

* 1. Imaging Equipment: No. of Units

Gamma Camera SPECT SPECT-CT PET PET-CT 

* 1. Non Imaging Equipment:

Thyroid Uptake Probe  Any Other 

* 1. High Dose TherapeuticFacilities:

No. of Isolation Rooms Capacity of each delay tanks(in lts) 

* 1. Sealed Sources (Calibration & Check Sources) is available: **Yes**/~~No~~

If yes, provide the date of purchase: **xxxxxxx**

* 1. Disused sources (Calibration & Check Sources)is available: ~~Yes~~/**No**
  2. Whether separate area is earmarked for Low Dose therapy administered patients. ~~Yes~~/**No**
  3. In case of disused sources, whether the institute has plan of ~~Yes/No~~/**NA** action for disposal of the same?

# Availability of Operating Personnel

* 1. No. of qualified Nuclear Medicine Physician available, areas per  current AERB Safety code for NM facilities:

*Name of the NM Physician and his RP ID*

* 1. No. of qualified Nuclear Medicine Technologists available, areas per  current AERB Safety code for NM facilities

# PersonnelMonitoring

* 1. Institute personnel monitoring number **xxxxxxx**
  2. Personnel monitoring device (PMD) is provided to all radiation workers? **Yes**/~~No~~
  3. PMD is provided to the trainees(if any)? ~~Yes/No~~/**NA**
  4. Proper storage of PMD is available? **Yes**/~~No~~
  5. PMD are being worn by workers appropriately? **Yes**/~~No~~
  6. Whether dose records available? **Yes**/~~No~~
  7. Radiation workers are informed about their monitoring results? **Yes**/~~No~~
  8. Whether PMS was suspended any time during last one year? ~~Yes~~/**No**
  9. Whether any over-exposure is reported during last one year? ~~Yes~~/**No**
  10. If yes, whether dose recorded was found to be genuine? ~~Yes/No~~/**NA**
  11. Whether adequate measures have been taken to avoid recurrence? ~~Yes/No~~/**NA**

# Radiation measuring/protection level equipments

|  |  |  |
| --- | --- | --- |
|  | **Working (Yes/No)** | **Date of calibration** |
| **a)** Survey meter | **YES** | **19.04.2019** |
| **b)** Contamination Monitor | **YES** | **19.04.2019** |
| **c)** Dose Calibrator | **YES** | **10.04.2019** |
| **d)** Gamma Zone monitor | **NO** | **NA** |
| **e)** Appropriate phantom and QA tools | **YES** | **NA** |
| **f)** Direct Reading Dosimeters(DRD) | **YES** | **22.06.2019** |

1. **Handling/General Facilities**
2. Where relevant , are the following operational Fume Hoods

L-Bench Lead Bricks Sink

Remote Handling Tools Lead Apron & Gloves Decontamination Kit Hand Gloves

Syringe Shield Syringe Carrier

Warning symbol displayed at appropriate places Gamma Zone monitor

Patient viewing system Emergency procedures displayed

Whether physical security of the source is ensured

## Available Working Yes/No/NA Yes/No/NA

**YES YES**

**YES YES**

**YES YES**

**YES YES**

**YES YES**

**YES YES**

**YES YES**

**YES YES**

**YES YES**

**YES YES**

**YES YES**

**YES YES**

Conventional safety ensured( preventive measures for flooding and fire safety)**YES YES**

1. Whether the flooring in the laboratory is smooth **Yes**/~~No~~ If yes, which type of flooring: **VINYL**
2. Whether work surface is smooth & covered with adsorbent sheet: **Yes**/~~No~~
3. Whether Doors & Walls are painted with smooth and washable paints: **Yes**/~~No~~
4. Whether separate rooms are provided for each of the radioactive

operations as per guidelines: **Yes**/~~No~~

1. Whether sinks are provided in each of the rooms where radioactive material is handled: **Yes**/~~No~~
2. Whether Radiation warning symbols are displayed where required: **Yes**/~~No~~
3. Whether emergency procedures for radioactive spillage

misadministration are pasted at appropriate place in the facility: **Yes**/~~No~~If yes, attach photograph of the same.

1. Whether type of taps fitted at the sinks are elbow-operated: **Yes**/~~No~~
2. Whether Sinks are made of Non-porous material like SS or Glazed Ceramic: **Yes**/~~No~~
3. Whether Ventilation of the radioactive handling rooms is satisfactory: **Yes**/~~No~~
4. Whether illumination inside the radioisotope laboratory is satisfactory: **Yes**/~~No~~
5. Whether Separate drainage system provided for Nuclear Medicine facility: **Yes**/~~No~~
6. Whether the Delay tank is properly cordoned off: **Yes**/~~No~~ If yes, attach photograph of the same.
7. Whether any provision is made for indication of Radioactive

Effluent levels in the delay tank: **Yes**/~~No~~

If yes, attach photograph of the same

1. Whether QA of the equipment has been performed **Yes**/~~No~~
2. Whether any upgradation carried out in the unit ~~Yes~~/**No** (if yes, whether permission obtained for the same) ~~Yes/No~~/**NA**
3. Whether radiation protection survey performed: **Yes**/~~No~~
4. Maintenance records of the imaging equipment available: **Yes**/~~No~~
5. Whether following logbooks are made available?

Patient Information Data: **Yes**/~~No~~

Activity procurement and usage: **Yes**/~~No~~

Disposal of Radioactive Waste: **Yes**/~~No~~

Radiation Protection Survey Report: **Yes**/~~No~~

Minutes of Local Safety Committee: **Yes**/~~No~~

PMS Data: **Yes**/~~No~~

Sample Collection data for Delay Tank: **Yes**/~~No~~

## Unusual Incidents /Accidents

* 1. Any radiation emergencies encountered: ~~Yes~~/**No** If “Yes” then details
  2. AERB was informed about the incident: ~~Yes/No~~/**NA**
  3. Follow up action to prevent occurrence taken: ~~Yes/No~~/**NA**
  4. Any clinical trial planned in the institute: ~~Yes~~/**No** If yes, whether reviewed by ethics review committee: ~~Yes/No/~~**NA**

# Observations:

*(Attach extra sheet, if necessary)*

We the undersigned hereby declare that the informations furnished above is correct to the best of our knowledge, and if found, at any stage, that the information provided by us is false and/ or not authentic, then we hereby accept that appropriate regulatory actions as deemed fit may be initiated against us and our institution, in accordancewiththeapplicablerulesstatedinAtomicEnergy(RadiationProtection)Rules, 2004; which may even leads to revoke of license.

Moreover, the regulatory requirements as stipulated in AERB safety code on Nuclear Medicine facilities AERB/RF-MED/SC-2 (Rev.2) will be ensured during the routine operation our Nuclear Medicine facility.

signature

(Name and signature of RSO with seal)

Counter Signed By:

Signature and seal

(Name and Signature of Employer with Seal) (Name and Signature of Licensee with Seal)

HIGH DOSE THERPY WARD

MOBILE LEAD BARRIER

Image 1

TANK MONITORING SYSTEM

Image 2