DEPARTMENT OF HEALTH

BUREAU OF RADIATION CONTROL

SEMI-ANNUAL ADVISORY COUNCIL MEETING

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Tampa International Airport

Tampa, Florida 33607

Reported By:

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1 A P P E A R A N C E S

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3 Advisory Council on Radiation Protection Members

4 Dr. William Atherton, DC, DACBR, CCSP

Carol Bonanno, CNMT

5 Paul Burress, CHP

Kathleen Drotar, MEd, RT

6 Dr. Warren Janowitz, MD, JD, FACC, FAHA

Timothy Richardson, RT

7 Alberto Tineo, CNMT

8 Bureau of Radiation Control Staff

9 James Futch, Administrator

Cindy Becker, Administrator

10 Janet Cooksey, Management Review Specialist

Brenda Andrews, Business Consultant

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Mark Whitten, Executive Director, MQA

13 Gail Curry, Regulatory Consultant, MQA

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1 Thereupon, the following proceedings commenced:
2 DR. JANOWITZ: Good morning, everyone. Get
3 started. Glad to see you all here this morning. Why
4 don't we -- I think most of us know each other, but why
5 don't we start with introductions.
6 DR. ATHERTON: Hi. Bill Atherton. I'm a
7 Chiropractor in Miami, Florida.
8 MR. BURRESS: Paul Burress with Florida State
9 University.
10 MS. BONANNO: Carol Bonanno, and I represented the
11 Florida Nuclear Medicine Technologists, and I'm
12 retired.
13 MS. DROTAR: Kathy Drotar, Department Chair with
14 Keiser University Department of Radiology and Radiation
15 Therapy.
16 MR. RICHARDSON: Tim Richardson, Program Director
17 for Marion County School of Radiologic Technology, and
18 I represent the Florida Society of Radiologic
19 Technologists.
20 MS. DeLOATCH: Nancy DeLoatch. I'm a guest.
21 MS. BECKER: Cindy Becker. I'm with Radiation
22 Control.
23 DR. JANOWITZ: Warren Janowitz. I'm head of
24 Nuclear Medicine at Baptist Hospital in Miami.
25 MR. FUTCH: James Futch, Bureau of Radiation

1 Control, Florida Department of Health.
2 MS. ANDREWS: Brenda Andrews, Bureau of Radiation
3 Control.
4 MS. COOKSEY: Janet Cooksey, Radiation Control.
5 MR. TINEO: Albert Tineo, Halifax Medical Center,
6 Daytona Beach.
7 MS. CURRY: Gail Curry. I'm with EMT, Paramedics,
8 Rad Techs Certification Unit.
9 MR. WHITTEN: Mark Whitten, Executive Director,
10 Board of Pharmacy, Certification Office for EMTs,
11 Paramedics and Rad Techs.
12 DR. JANOWITZ: Good morning, everyone. So I think
13 the first order of business is the approval of the
14 minutes. I think they were distributed by e-mail.
15 MS. ANDREWS: Yes.
16 DR. JANOWITZ: Are there any comments or
17 corrections?
18 Motion to approve the minutes?
19 MR. TINEO: So moved.
20 MS. BONANNO: Second.
21 DR. JANOWITZ: Any opposed?
22 (None)
23 DR. JANOWITZ: I think I'll turn this over now to
24 James.
25 MR. FUTCH: I just want to say thanks again for

1 everyone coming and taking time out of your busy --
2 busy lives and helping us out with work of radiation
3 control in Florida. We do have one guest Nancy
4 McDonald DeLoatch.
5 Is that how you pronounce it.
6 MS. DeLOATCH: Yes, sir.
7 MR. FUTCH: A practicing nuclear medicine
8 technologist --
9 MS. DeLOATCH: I am.
10 MR. FUTCH: -- in Florida and --
11 MS. DeLOATCH: I am the clinical instructor for the
12 Program of Nuclear Medicine Technology, and I also sit
13 on the Board of Directors for EMT.
14 MR. FUTCH: Right. And Nancy was kind enough to
15 come down -- this is going to come up in a later
16 discussion we're going to have about the new types of
17 licensure that we have available to us in Florida and
18 some insight into NMTCB's section of types of
19 certification.
20 Janet, do we have anything else before we get
21 going?
22 MS. COOKSEY: Brenda, I think, wants to go to
23 travel.
24 MS. ANDREWS: You may to --
25 MR. FUTCH: Go ahead.

1 MS. ANDREWS: I have travel packets for everyone
2 underneath your -- your notebooks. If you have any
3 questions, let me know; however, if you can fill this
4 out now, if you just had mileage and you know what --
5 how to go ahead and fill it out, then you can do that
6 and turn it back in to me.
7 There's the worksheet here that's in your packet,
8 and also, this is a sheet for you to sign and date, and
9 that's all you do with this. If you're going to turn
10 the packet back in to me, make sure you do not fold
11 this. I have provided envelopes for you to return them
12 in if you wanted to do it that way.
13 MR. FUTCH: So we'll fill in your banking
14 information later.
15 (Laughter)
16 MS. ANDREWS: But the instructions are there, so
17 if you can fill it out now and give it back to me, feel
18 free to do that. Otherwise, just mail it back in to me
19 when you get back home, and make sure you put all your
20 receipts in there too.
21 DR. JANOWITZ: I guess the next item is department
22 restructuring, Cindy Becker.
23 MS. BECKER: Oh, okay. Well, welcome, everybody,
24 at least to the Tampa airport, maybe not to Tampa, and
25 I wanted to thank Janet and Brenda for putting these

1 lovely binders together because it helps me a lot
2 because I can't read that far away.
3 But if you turn to Tab A, you will see the first
4 work chart is our current organizational chart. I
5 don't know how long it will be current. We have not
6 had an official date, have we, of when it's to take
7 place, but we're all assuming, you know where that gets
8 you, July 1 or probably thereabouts.
9 But right now on this first page, you will see we
10 are still called Bureau of Radiation Control. We are
11 in the Division of Environmental Health, which is under
12 the Department of Health umbrella and that -- that
13 we're with the other bureau, as you can see. We're
14 with the Division of Environmental Health.
15 If you turn the page, the back side is what's
16 proposed, and what we understand will happen. The
17 Division of Environmental Health is becoming the Bureau
18 of Environmental Health. So since we will no longer
19 have a division to report to, we are being transferred
20 to the Division of Emergency Preparedness and Community
21 Support. You'll see that's highlighted here, and we
22 will be having a slight name change. We will be the
23 Bureau of Radiation Prevention and Control. We did not
24 choose that name.
25 MS. BONANNO: We're going to prevent radiation?

1 MS. BECKER: There it is.
2 MR. FUTCH: Get all the jokes out now.
3 MS. BONANNO: Okay.
4 MS. BECKER: Afraid so.
5 MR. FUTCH: We're also preventing water and air at
6 the same time. We're doing radiation first.
7 MS. BECKER: Don't breathe. Right? You will see
8 the other bureaus that are also there with the Division
9 of Emergency Preparedness and Community Support, and on
10 the next page, you'll see that this is broken down a
11 little bit, showing the division and the five bureaus.
12 There's still a bureau to be named. They're still
13 doing a little bit of tweaking, but as far as we know,
14 we're going as an entire whole bureau to this division,
15 which hopefully will mean that it should be very
16 transparent to everyone out in the field and also, we
17 hope, to our staff.
18 We have not heard if there will be a physical move
19 involved with the folks in Tallahassee. That may
20 happen. It may not. It'd be better for us if not, but
21 we don't know that part yet either. We do have one of
22 our field offices located -- the A. G. Holley Hospital
23 in Lantana, we have four staff located there. That
24 hospital is closing down June 30th, and so we have to
25 move by then. So we are in the process of -- Brenda

1 is -- she's our move specialist -- in the process of
2 trying to locate space for us. If not, they may be
3 working from their homes, which is the way we have been
4 moving any way for the inspection staff.
5 Other than that, I think can't of any other
6 organizational issues I have heard of. Every day we
7 hear a little bit more news, little bits and pieces,
8 not really any big news for us as far as the Bureau,
9 and that's good because we are staying as a whole
10 bureau, and other bureaus were not as lucky.
11 So does anybody have any questions related?
12 MS. BONANNO: Who did this, just out of curiosity?
13 MS. BECKER: Where did it first start?
14 MS. BONANNO: Yeah.
15 MS. BECKER: I guess it first started with the
16 legislature deciding the Department of Health was too
17 large, and, you know, how it's -- I know if you've been
18 here many years you've seen it, oh, it's too large. We
19 need to get it down to the local levels. Oh, we don't
20 want local levels. We want it all together. So to me
21 it's just a roundabout cycle again.
22 So then it got assigned to a group that was a
23 team, a reorganizational team, that met with different
24 top leaders and worked out a plan, and this was their
25 plan.

1 So what else? Anything else about that, James,
2 that you know about?
3 MR. WHITTEN: Nothing he's going to say.
4 MS. DROTAR: The staff, is it going to stay
5 intact?
6 MS. BECKER: Yes.
7 MR. FUTCH: We are moving to a division that is --
8 has other, I guess what you might call, statewide
9 services like radiation control. There's a lot of the
10 department that works through county health
11 departments. The division that we're in right now that
12 we're moving from almost -- I think the vast majority
13 of the work is performed by local county health
14 department staff, and the folks in Tallahassee write
15 the regulations and set the standards and so forth.
16 This new division of Emergency Preparedness, for
17 example, one of the sister bureaus is the Bureau of
18 Public Health Laboratories. I forget how many there
19 are, but there's several public health labs around the
20 state, including one in Tampa. So from that
21 perspective, I guess it might be -- there's some
22 benefit to having other folks who are focused more on
23 our own people doing the services directly in different
24 parts of the state, rather than working through the
25 county health departments.

1 DR. JANOWITZ: Does the Emergency Preparedness and
2 Response Bureau handle radiologic emergencies, or how
3 does that go?
4 MR. FUTCH: No. We still have the subject matter
5 expertise inside radiation control for emergency
6 response to -- to radiation accidents, incidences that
7 are required, but those folks inside our office know
8 some of the people in the Bureau of Emergency
9 Preparedness who handle other things, like, I don't
10 know what, hurricanes, whatever else happens out there,
11 not radiological. So there's also some benefit to
12 that. There will be some people there that we can work
13 with.
14 DR. JANOWITZ: Does this affect the budget lines
15 or?
16 MS. COOKSEY: Not so far.
17 MS. BECKER: Not so far. Now we have a new State
18 Surgeon General effective tomorrow, Dr. Armstrong, so
19 they have begun the appointment from the top up.
20 Everybody is still interim acting status, so all we've
21 heard on that is they're going to start from the top up
22 and then move on down.
23 MR. FUTCH: And that includes departmentally our
24 future Division Director but also our Bureau Chief who
25 is retiring as of the end of the month. Is that?

1 MS. COOKSEY: Uh-huh.
2 MS. DROTAR: Bill's retiring?
3 MR. FUTCH: Cindy's acting, and we kind of get the
4 feeling that everyone's waiting for the new Surgeon
5 General to appoint the new Deputy Secretaries who
6 appoint the new Division Directors who then appoint the
7 Bureau Chiefs.
8 MS. BECKER: All the way down. We have an Acting
9 Division Director. Victor Johnson is Acting Division
10 Director of the Division of Emergency Preparedness and
11 Response or -- how can we have that? The Division of
12 Emergency Preparedness and Community Support -- yeah,
13 Community Support, but they changed their name as well.
14 We all have to get use to our name changes.
15 DR. JANOWITZ: Hopefully, everyone will be
16 appointed before we have a new Governor.
17 MR. BURRESS: Where did the radon folks end up?
18 MS. BECKER: Radon ended up in the Bureau -- you
19 can see it up here. They went with Carina Blackmore,
20 if I can see it up here, or do we not see it at that
21 level?
22 MR. FUTCH: Which table are you on? The one in
23 the middle.
24 MS. BECKER: Yes. The one on the back page. They
25 went to Bureau of Epidemiology, I believe. I think

1 that was the Carina Blackmore section.
2 MR. FUTCH: It's still in indoor air, isn't it?
3 MS. BECKER: Yeah, indoor air. Yeah, and you
4 don't see it break down as low as that.
5 DR. JANOWITZ: It's not environmental?
6 MS. BECKER: No. They did not stay in the Bureau
7 of Environmental Health. They went to the Bureau of
8 Epidemiology. Yeah. Environmental medicine I think is
9 their section. They tried to stay in radiation
10 control, or go with us, I should say, but it did not
11 happen that way.
12 DR. JANOWITZ: Okay. The next item on the agenda,
13 MQA update.
14 MS. CURRY: We just wanted to kind of give you all
15 some numbers. This is based on -- from our fiscal year
16 of July 1st until May 15. We wanted you to know that
17 we've approved 1,619 applications. Out of those, we
18 have licensed 1,508 of those, and we have renewed 9,808
19 licenses.
20 And the only other thing we were going to talk
21 about, which I know we talked about last year, is the
22 electronic verification for schools so you don't have
23 to do the letters any longer. I know ARRT has that
24 capability. We are working on that, but we kind of
25 keep getting bumped for other things, especially with

1 the legislature getting over with and that. There's
2 lots of things that IT has to put in place before our
3 electronic verification. So hopefully, that will be
4 out by the next meeting.
5 DR. ATHERTON: Those licensees are all licensed in
6 Florida?
7 MS. CURRY: It's basic x-ray machine operator,
8 general radiographer, nuclear medicine and radiation
9 therapy. The majority of them are general
10 radiographers. I think I had somewhere our basic x-ray
11 machine operators who had a pretty good bit of those.
12 482 of those were basics. So that's it.
13 MR. WHITTEN: I have nothing. I guess one thing.
14 We are currently processing at 1.7 days.
15 MS. CURRY: Oh, yeah. 1.7 days.
16 MR. WHITTEN: So we're pretty efficient.
17 MS. CURRY: That's from the time the application
18 hits our office because there is a small process before
19 that where the application comes into the office, the
20 money gets deposited, demographics are put in, and then
21 it's sent to our office. So we are working at 1.78
22 days.
23 MS. DROTAR: I just wanted to say with the new
24 system and doing the applications online -- because I
25 graduate three classes a year, and it has been so

1 smooth, the process of having the students do the
2 application online and being able to just use a credit
3 card to do it. I know everybody got the license
4 applied for, and sending the letters isn't a being deal
5 at this point. It'll be even nicer and smoother when,
6 you know, but the students, when they graduate, are
7 able to go to work the next week if they find a job,
8 and, you know, kudos to you guys for making it such a
9 smooth process.
10 MS. CURRY: Thank you.
11 MR. WHITTEN: We're actually working with the Bank
12 of America. Right now at times we're waiting on money
13 to clear. Actually, some of that 1.78 days are -- we
14 could probably have these done at a half a day, but
15 we're renegotiating our contract with Bank of America
16 so there will be an automatic release of funds, and as
17 soon as we have everything, they're approved.
18 DR. JANOWITZ: Moving off topic since we have
19 plenty of time, how is the job situation for new
20 graduates?
21 MS. DROTAR: It depends on what part of the state
22 you're in. Because we have the 12 different campuses
23 and -- and we just had a program directors meeting last
24 week. In my area, things have picked up down in
25 Sarasota. Some of the other campuses have seen a turn

1 around where there is not as many jobs open, and
2 there's a lot of, in our area any way, new outpatient
3 facilities, free-standing, so that's helped a lot and
4 urgent care places that have an x-ray machine, so
5 they're able to go in there and do both sides of, you
6 know, front and back kind of thing.
7 But we're probably, I would say, at about 75
8 percent of our graduates have jobs. But it's --
9 it's -- and that's not to say that there aren't
10 openings, but what I see a lot of is that there are
11 positions, but they're not filling the positions
12 because of budget crunches, et cetera.
13 MR. RICHARDSON: We're in a pretty encompassed
14 area, Marion, Citrus and Lake County, and we have about
15 a 90 percent placement rate right away, then 100
16 percent within about six months, so our area, believe
17 it or not, is still growing population-wise, building
18 hospitals, putting on wings. It's because we're
19 located by the Villages, if you all have heard about
20 the Villages.
21 DR. JANOWITZ: So you still have a good pool of
22 applicants.
23 MS. DROTAR: Yeah. What he says goes out to 2013,
24 May of 2013. So I have about four more classes that
25 are lined up and in the wings, but people are still

1 coming into the profession, so I haven't seen a
2 downturn there.
3 MR. RICHARDSON: We have about four times as many
4 people apply as we have spots for so, and needless to
5 say, we pick the best and the brightest. We try to,
6 any how.
7 DR. JANOWITZ: Any other comments?
8 MS. DROTAR: Can I add to that? JRC is -- to meet
9 DOE guidelines, we're going to have to publish all the
10 approved college or -- yeah, programs are going to have
11 to post their job placement and their completion rates,
12 so that will be updated on an annual basis, but it will
13 be information to the public to see what different
14 schools are doing.
15 DR. JANOWITZ: Okay. I guess we can move on to
16 Rubidium 82.
17 MR. FUTCH: Actually, before we do that, if we
18 could, we have to decide where we're going to have
19 lunch. Take care of the important things. The Tampa
20 airport has been kind enough to provide us with not
21 one, but two places to eat, Carrabba's or TGI Fridays,
22 both of which can accommodate a large group.
23 So shall we do a show of hands who feels more like
24 Carrabba's, or I'll just then say TGI Fridays must be
25 where you all want to go. Right? Does anybody care?

1 Brenda, why don't you decide and surprise us,
2 whichever place.
3 MS. DROTAR: Maybe just make sure that they'll do
4 separate checks.
5 MR. FUTCH: Oh, separate checks and quickly.
6 MR. RICHARDSON: And if we don't like it, we're
7 going to blame you, you know.
8 MS. ANDREWS: Well, don't worry about me. I can't
9 pay for anything. My wallet's in Ocala.
10 MR. FUTCH: What's important, though, is she
11 doesn't actually live in Ocala, but we did stop there
12 for lunch yesterday on the way here.
13 MS. ANDREWS: And my wallet decided to stay.
14 MS. BONANNO: And it likes Ocala.
15 MS. ANDREWS: It likes Ocala. I'm offended.
16 MS. BONANNO: Probably wants to move to the
17 Villages.
18 MR. FUTCH: There was like this great
19 gravitational force as we're driving down the
20 interstate. I wanted to turn to the left.
21 I'm sorry. Go ahead.
22 MS. BECKER: I started with the updated slides.
23 These are slides that Mike Stephens from our bureau put
24 together for the Health Information Control Program
25 Directors Meeting in Orlando, which was last week, week

1 before. I can't think now how far away that was. Week
2 before last. This starts in the middle of his
3 presentation. I think we had a pretty good thorough
4 update. I was not here but --
5 MR. FUTCH: I'm not sure everybody was here for
6 the update last time. Dr. Janowitz and Alberto weren't
7 here.
8 MS. BECKER: Okay. Do we have the other slides on
9 there?
10 MR. FUTCH: Yes.
11 MS. BECKER: Otherwise I can read to you the
12 minutes from last time, and that would be very boring,
13 I'm afraid.
14 Okay. Thank you to Mike Stephens for putting this
15 together.
16 They also had -- at the conference, they also
17 had -- Braco was there, the manufacturer, and somebody
18 from Nevada Bureau of Radiation Control, as well as FDA
19 and CDC. They were all there during the presentation,
20 so I took notes. I'm going to try to reproduce the
21 topic they had.
22 This was the issue some of you heard, and I guess
23 a few of you had not heard, the event that took place,
24 not only in Florida, but in Nevada, and I guess we can
25 start. Okay. Next slide.

1 What happened is customs and border patrol between
2 Canada and the United States has radiation detection
3 equipment. They picked up -- a couple of folks going
4 through their customs and patrol set off their
5 radiation detection alarms, and they discovered that it
6 was strontium that they were picking up.
7 They traced back these patients from PET scans,
8 and there was patients from Nevada and from Florida as
9 well. It says 379 patients, calibration records,
10 break-through records. I'm trying to skip this slide.
11 Go to the next slide. Oh. Okay.
12 This is some charts that we pulled up at the -- at
13 the site. I had to go back. This site -- I'm sorry.
14 Keep going. Go to the next slide. I didn't realize he
15 had put all the beginning stuff on there. Need to go
16 forward.
17 All right. That slide. That's perfect. Okay.
18 Now I can give you a little bit of history. So what
19 happened in tracing these patients back to facilities
20 that were in Nevada and in Florida, they discovered
21 that the scans were done using a rubidium/strontium
22 generator, and these generators have strontium as
23 their -- it's a break-through product that is not
24 suppose to be seen at much of a high rate, and, as I
25 guess you know, the people and med techs here, that

1 what they're trying to get is the rubidium, which has a
2 75 percent half-life. It's a very good material to use
3 the scanning because it's gone very quickly, so it's
4 very good for the image and for the patient.
5 But what was happening is more strontium was
6 breaking through, and it was absorbing into the
7 patients, and this was months later these were being
8 detected from the radiation detection devices that were
9 at the border and customs patrol.
10 So FDA got involved. They recalled all of the
11 generators, which were manufactured by Braco or Braco,
12 however you want to say their name.
13 MR. FUTCH: Carol could tell us.
14 MS. BECKER: Is it Braco?
15 MS. BONANNO: It's Braco.
16 MS. BECKER: Okay. Braco. I hate to say it, but
17 they were the manufacturer of the devices and also, I
18 believe, Los Alamos National Laboratories also checked
19 the devices and could not really find anything
20 malfunctioning, so it became what is going on with how
21 they're being used, and that's where we came into play.
22 They asked Florida and Nevada to do some testing
23 at facilities to find out how they were being used. 21
24 of the 30 facilities that did have these devices in
25 Florida they were able to visit, and this then becomes

1 the results of that visit.
2 The -- 9 the 21 sites were recording zeros.
3 Instead of the actual break-through number, they simply
4 recorded, oh, it's a zero. 18 of the sites did not
5 record zeroes, but even though they were over
6 regulatory limits -- 5 of the 18 were over the
7 regulatory limits. They did not report it, and they
8 kept using them. So they only not stopped using the
9 device, they used it on patients and then also did not
10 report it to us as required.
11 So we had a ton of patients, needless to say, that
12 probably were scanned with this with using the
13 generators. We thought maybe as many as 35,000
14 patients in Florida. This is during the timeframe of
15 February to July of 2011. Only during that time period
16 were these generators in use. They have a life span of
17 use. I think it was 25, 28 days. Does that sound
18 about right? If I recall.
19 Have I missed anything about bringing anybody up
20 to date? Because now I've come to the point, I think,
21 from last time that we go into what we did after this
22 point.
23 DR. ATHERTON: What's the half-life of strontium?
24 MS. BECKER: Strontium is 64 days, but now the
25 rubidium is 75 seconds.

1 MR. FUTCH: This is actually -- I haven't seen
2 this, but this is actually hooked up, Carol, to the
3 patient?
4 MS. BONANNO: Directly to the patient. The
5 generator is diluted directly into the patient.
6 MR. FUTCH: It's so short, you have to do that.
7 So no syringe in between.
8 MS. BONANNO: Yeah. No dose calibrator in
9 between. There's a dose calibrator built into
10 injection machine.
11 MS. BECKER: See if I missed anything. Everybody
12 understand? It's kind of messy.
13 MR. FUTCH: I guess at one point, FDA asked CDC to
14 become involved in trying to do an epidemiological
15 study of what happened with all the patients or a
16 sampling of the patients in order to figure out what
17 happened with all the patients. That's who asked us to
18 go and do a lot of these meetings.
19 MS. BECKER: And that should be the next slide.
20 DR. ATHERTON: I'm still a little confused on you
21 said it wasn't the machines that were malfunctioning.
22 It was how they were being used?
23 MR. FUTCH: Well, Los Alamos couldn't get them to
24 malfunction in the manner in which they were testing
25 them.

1 DR. ATHERTON: Okay. But here were some
2 malfunctioning and then they were --
3 MS. BONANNO: The machines didn't malfunction.
4 The technologists malfunctioned.
5 MS. BECKER: Yes. They were using them past their
6 lives for one thing, and I think the way they were
7 drawing the doses too much without salt volume, I
8 understand.
9 MS. BONANNO: Yeah. The more saline that goes
10 over the generator over time, the more likely you are
11 to get strontium rates. So if you're doing more than,
12 let's say, eight patients a day, we have recommended
13 that you get a second generator and get one every three
14 weeks, rather than stretching it out.
15 MR. FUTCH: Carol, you're also suppose to use the
16 Braco saline or?
17 MS. BONANNO: No. No. You use regular old
18 saline, regular old saline. You have to be careful not
19 to use distilled water or glucose. That will ruin the
20 generator right now. It strips it.
21 DR. ATHERTON: So some were too old, and some were
22 being over used.
23 MS. CURRY: Yeah. Some were sites that do way
24 more than usual sites, and some were people that, I'm
25 embarrassed to say, didn't do their QC or didn't do it

1 properly. When you see a zero, there should not be a
2 zero. There's something. There's a little something
3 every day.
4 DR. JANOWITZ: One thing I heard was that the dose
5 calculations that were done by Homeland Security used
6 to be done at Los Alamos, and then they did their own
7 calculations, and supposedly they were not performed
8 correctly.
9 MS. BONANNO: That could be too. And they also
10 apparently lowered the cutoff after the tsunami at all
11 the borders. So if it happened in the past and people
12 went through, they wouldn't have even been picked up.
13 MS. BECKER: They've been in use for what? 22
14 years?
15 MS. BONANNO: Yeah.
16 MS. BECKER: Probably not a first time. Don't
17 want to say it's the last time but...
18 MR. FUTCH: Although, I think the -- you know, the
19 way these things normally work is they get an alarm
20 based upon a gross gamma reading, and then they'll pull
21 out a gamma spec --
22 MS. CURRY: Try to figure out what it is.
23 MR. FUTCH: -- and figure out what the material
24 is. Having done this myself for Florida for many
25 years, if you see something besides -- like, technetium

1 you're not going to think twice about, F18, you know,
2 anything like that.
3 If you see Strontium in a person, you're going to
4 question what's going on. I mean, you might think
5 that's some sort of, you know, usage that has nothing
6 to do with medicine.
7 MS. BONANNO: And I think some people didn't use
8 the dose calibrators correctly, I'm guessing. If they
9 got all zeroes, they had it set too high.
10 MS. BECKER: Yeah. That was one of the things
11 they did find. Things were not done right. Okay. I
12 think the next slide.
13 Wow. There it's talking about just what we were
14 talking about. Okay. If you look in your handout, by
15 the way, on Tab B, you will see three slides that we're
16 going to go over in a minute that bring this up. This
17 is an earlier slide that talks about what they found
18 with the generators.
19 No correlation between patient values and lot
20 number calibration date or time frames. Okay. When we
21 were collecting all the records from the 21 facilities,
22 we were trying to see if it did make a difference
23 between lot numbers. We could not find any difference.
24 Okay.
25 Next. This is when CDC stepped in and said, hey,

1 Florida and Nevada, will you help us determine what
2 really is going on here now with the patients? So we
3 provided three facilities. The index site where the
4 patients first came from was actually in Sarasota, but
5 Braco got there before anybody else did and started
6 testing the patients.
7 So we grabbed the three facilities in the Orlando
8 area, mainly because our lab was right there so we
9 could get the tests done very quickly using our
10 laboratory facilities. So the facilities were
11 contacted and asked if we could have them contact their
12 patients, which they agreed, and, of course, a lot of
13 patients were not available because they were down here
14 just temporarily, the snow birds, but we did manage to
15 get -- ended up with 123 patients, and we had one week
16 to do 123 patients, to scan them, our equipment.
17 So this now is your binder. So we counted 123
18 patients in the four days. That was done in October,
19 and these were patients that were originally imaged
20 between the February 17th and July 22nd date. That's
21 when the time frame that we think the first patient
22 was. It was months back that they found the strontium,
23 so we went all the way back to February 17th and then
24 ended, of course, July 22nd because by then FDA had
25 recalled all of the generators.

1 We did find of 123 patients five that were twice
2 backgrounded. The largest was actually 12 times
3 background, and I think background was considered to be
4 about 50 counts on our equipment for strontium, and we
5 had as high as a 6 out of 20 counts.
6 The largest dose -- well, nine patients went up, I
7 should say, for whole body counting at Oak Ridge
8 National Laboratories, and of those the largest dose
9 that we found was about 429 millirem whole body. Now,
10 I believe Nevada had one that they found as high, like,
11 12 rem. Do you remember that number being in there?
12 They found one quite a bit higher than we did. As --
13 oh, Nevada. I'm sorry. 4.9 rem, not 12. 4.9 rem.
14 Okay.
15 So what did that mean for us? Well, after we did
16 the testing and they went for the whole body scans, we
17 came back and started issuing, of course, our notice of
18 violation letters. These were for recording zeroes and
19 for not reporting to us. So we realized that this was
20 an issue, considering it occurred with so many of the
21 licensees, and did not want it to happen again, was
22 trying to prevent that as much as possible, but we
23 issued new license conditions for these medical use
24 licensees.
25 One was, of course, to follow the FDA package

1 insert. We have that here, if you wanted to go access
2 their site, but it basically instructs them to follow
3 the manufacturer manual and updates and all the
4 documents that come to them from the manufacturer.
5 Braco had claimed that they had sent warnings
6 about don't use the generator past this lifetime and
7 how to set -- set the -- so they don't set it all at
8 zero, how to set that, and they didn't follow the
9 instructor's manual or the updates or the associated
10 documents. Not every facility, but that seemed to be
11 pretty much what most of them were doing.
12 We also instituted a new training requirement
13 where they have annual refresher training with the
14 staff that use the generators. Now they have to start
15 collecting the data from the generators so that when we
16 inspect we can look at the data.
17 MR. FUTCH: Besides zeroes.
18 DR. ATHERTON: Is there -- the fines or the
19 letters in violation you sent out, is there a monetary
20 fine associated with those?
21 MS. BECKER: No, we did not issue fines.
22 DR. ATHERTON: Okay. Because it seems like the
23 only reason that the pressure to ignore the zeroes or
24 something would be -- eventually be monetary because
25 they don't want to buy a new generator. I wondered if

1 there was any monetary fine associated with the
2 violation.
3 MS. BECKER: Yeah. I think it wouldn't be a
4 good -- it would not be a good idea considering that
5 there was such a large scale issue going on with that.
6 I think if it happened in the future, that might be
7 something that we would consider, but it was such a
8 large scale, it would be kind of hard pressed to all of
9 a sudden to say, oh, we're going to fine everyone.
10 MR. FUTCH: Bill, I think there was -- judging by
11 the tremendous interest from the medical community to
12 get these generators back in use, I think there was a
13 pretty substantial monetary penalty that they paid
14 through not having them.
15 MS. BONANNO: The whole country paid.
16 MR. FUTCH: Yeah.
17 MS. BECKER: They couldn't use them for how long?
18 It was a couple months.
19 MS. BONANNO: They just started. There's seven
20 yet to start in Florida, but they started 20.
21 DR. ATHERTON: I was just curious.
22 DR. JANOWITZ: These cameras which were doing the
23 cardiac procedures were basically dead for six months
24 with no income. I mean, if there was a mixed-use
25 oncology scanner, then there could be, but in a

1 cardiology office where they were doing just cardiac,
2 they've had to shut down because this was the only
3 source of rubidium.
4 DR. ATHERTON: So the fine was built in?
5 MS. BONANNO: Yeah. And some people who didn't
6 have a problem had to suffer because of those who did.
7 MS. BECKER: It's always the case. Isn't it?
8 MS. BONANNO: That's true. I retired just before
9 this happened.
10 MR. TINEO: Did those facilities have a radiation
11 safety officer in place or -- to supervise what they
12 were doing or not? It was just most of it outpatient
13 centers?
14 DR. JANOWITZ: They all have to have one radiation
15 safety officer.
16 MS. BONANNO: They were all outpatient in Florida
17 but one.
18 MS. BECKER: Yeah. Outpatient facilities. They
19 were all, like, cardiology offices.
20 MR. FUTCH: And then you have the one more there
21 on the bottom.
22 MS. BECKER: Pharmacy. Yeah. The nuclear
23 pharmacy, that's a whole another -- a whole another
24 animal. They have multiple clients often who use the
25 same generator, so we had to issue a new license

1 condition for the nuclear pharmacy saying, you need to
2 keep track of how long this generator has been used.
3 That was the issue with them.
4 The next slide, Thoughts. Okay. As Carol said
5 earlier, volume does appear to matter, and the main
6 issue still seems to be that the licensee has to be
7 aware of the licensing and manufacturer requirements
8 and follow them. So the sites -- they had training,
9 and they documented that they had the training. They
10 seemed to know how to use the generator.
11 MS. BONANNO: They got in a hurry.
12 MS. BECKER: But when you record zeroes, that's
13 not good. The generators, like it says on the fourth
14 bullet there, were not available for testing because,
15 realize, they were already used and sent back, so you
16 had that going. Reporting breakthrough is important
17 because it may have been discovered sooner if they
18 actually had reported the true numbers they were
19 seeing. They might have said, oh, we're having more
20 breakthrough than we're suppose to have. And I don't
21 even like the last bullet, but let's hope it doesn't
22 happen again. That was truly a mess for everybody.
23 DR. JANOWITZ: Carol, you could probably answer
24 this, but my understanding is Braco's instituted some
25 pretty stringent QA?

1 MS. BONANNO: Yes. As a result of the FDA's
2 request. Right now every site sends in the QC every
3 day to the appropriate --
4 MR. TINEO: With zeroes on it?
5 MS. BONANNO: They review that every day, and then
6 they send it on. There's a data person in house that's
7 reviewing all of those. They're not happy about doing
8 that, but that's what they have to do. They e-mail it
9 to the apps persons every day. Because I sat by her at
10 the FMT meeting and looked at her computer. She was
11 reviewing one day's worth. So yeah, they're pretty
12 strict right now, and I don't know if that will last.
13 MR. FUTCH: How are they reporting the numbers
14 now? Someone has to read something and write it down
15 somewhere and type it in?
16 MS. BONANNO: That form you saw they fill out, I
17 think they've changed that form a little bit, and
18 that's what you would get is those daily forms, the
19 three pages.
20 MR. FUTCH: I was wondering if there's something
21 from the Braco system that would maybe print out what
22 the breakthrough is, and that must be given to the
23 corporate office.
24 MS. BONANNO: Well, if the new infusion system
25 ever gets approved, that's all built in with a computer

1 in it. It will be done automatically. When that
2 happens, we'll have computer errors instead, which is a
3 problem.
4 MR. RICHARDSON: What kind of counters do they use
5 to measure those doses?
6 MS. BONANNO: Well, there is -- within the fusion
7 system, there is a base -- or a positron counter, and
8 that's checked every day against the dose calibrator.
9 The dose calibrator is the gold standard and if it --
10 if they don't match, then the fusion system is
11 calibrated and the results are repeated until it does.
12 One thing that's kind of interesting is the
13 different sites in Sarasota that about -- just before I
14 left, I got a phone call from them one morning saying
15 their breakthrough was a little higher than it had
16 been. It wasn't breakthrough. The strontium was
17 higher than it should have been, and I had the
18 application person with me, and she said, repeat it at
19 noon, and call me back. They repeated it at noon, and
20 they called us back and said it was even higher. She
21 said shut down, and they did right then and there.
22 They did no more patients for two weeks until they got
23 a new generator, but it was a different site but in the
24 same city and the tech had trained at that other site.
25 MR. FUTCH: So there's a kind of a rough

1 correlation that during the day if you're just testing
2 it once and you're testing it in the morning --
3 MS. BONANNO: Yeah.
4 MR. FUTCH: -- is it reflective --
5 MS. BONANNO: And they have a letter. Everyone
6 has a letter in their binders that says if you start to
7 see an increase, you are to -- it's a letter from
8 Braco. It says you should repeat it again that day,
9 and if it's high, you're to call Braco immediately.
10 Now they have to call the State too. That's fine. I
11 think that's great.
12 MR. BURRESS: Is the breakthrough, is that
13 percentage, the .02, the percentage of the total dose
14 can be breakthrough product or is it units, like so
15 many micro?
16 MS. BECKER: Is it a percentage or a unit?
17 MS. BONANNO: It's a ratio of strontium to
18 rubidium.
19 MR. BURRESS: So 2 percent -- .02 would be 2
20 percent.
21 MS. BONANNO: It's lower than that. It's very
22 low.
23 MR. BURRESS: And they base the allowable limit on
24 the annual limit?
25 MS. BONANNO: Something that was established by

1 FDA when the product was first approved. The same
2 thing for technetium. If you still have a generator in
3 your hospital, which nobody does anymore, you measure
4 the molybdenum. Molybdenum can break through just as
5 easily. Not as easily, but it can break through. I
6 never saw it in my years, but we checked it every day
7 and then given was a ratio of how many microcuries per
8 millicurie.
9 DR. JANOWITZ: You got to realize as the generator
10 gets older, you have to pass a lot more --
11 MS. BONANNO: A lot more saline through it.
12 DR. JANOWITZ: -- saline though it to get the
13 activity.
14 MR. BURRESS: We had a graduate student 10 or 15
15 years ago that worked in a lab using radio isotopes and
16 contaminate her stool, and it wasn't the P32 she was
17 working with, and I found out she'd had a nuclear
18 medicine procedure done. So we thought, okay. Well,
19 no problem. It's probably from that, but it never
20 decayed. It looked like it was tech 99, and the stool
21 never decayed, and when I calculated it, it was just a
22 few hundred picocuries, and I looked back then at what
23 the breakthrough was allowable, and it was way lower
24 than even -- you know, even a fragment of that thing,
25 but I don't know if she sweated this out or urinated it

1 out, but it was the only place in the laboratory, and
2 with HIPAA and all, I didn't want to embarrass her and
3 say, exactly what happened here, but I wondered how
4 common this is because all the QA/QC is done a priority
5 before the treatment. Right? Or the patients have to
6 go back to be rescanned? Or would it just get caught
7 at, like, a customs clearance checkpoint?
8 MS. BONANNO: That's why people who have thallium
9 scans sometimes -- they carry a note with them to take
10 a flight because thallium's got a longer half-life.
11 DR. JANOWITZ: I was visiting Turkey Point once
12 many, many years ago. There was a group of us. One of
13 the guys in the group had had a thallium scan about a
14 week ago, and as I was passing through the detector, I
15 kept setting it off because he was in the same room.
16 It took a while before they'd let us out of the plant
17 because they monitor you going out, not going in.
18 DR. ATHERTON: My question was maybe just a
19 followup to Paul. Is there any figures of the
20 potential harmful effects of that strontium in the
21 body? Is it too low for any concern?
22 MR. FUTCH: Don't hold me to anything technical
23 that's about to come out of my mouth. Wasn't the
24 medical event threshold at 5? And even the Nevada side
25 just under the effect. So all the rest of this in

1 Florida is way, way under.
2 MS. BONANNO: Way under. Probably less radiation
3 than they would have gotten if they'd had a thallium
4 scan.
5 DR. JANOWITZ: And if you look at a thallium --
6 thallium cardiac study, which is done on millions of
7 people, the typical dose would be about half of what
8 that maximum dose was in Nevada, so and people have
9 these twice a year sometimes, and so I mean, it's not
10 something you want to see, but it's probably not
11 tremendously dangerous.
12 MR. FUTCH: I think you don't want -- to the
13 individual, it wasn't a significant thing, but do you
14 want the entire country to be using the generator
15 that's increasing the overall radiation dose to all of
16 those people all the time by whatever amount?
17 DR. JANOWITZ: It's not like the CT scanners where
18 people were losing their hair.
19 MS. BONANNO: Yeah. It wasn't like that.
20 MS. BECKER: It was just a mess.
21 MS. BONANNO: I'm so sorry to have missed it.
22 DR. JANOWITZ: It probably cost Braco hundreds of
23 millions of dollars.
24 MS. BONANNO: Probably what?
25 DR. JANOWITZ: Cost Braco hundreds of millions of

1 dollars.

2 MS. BONANNO: Hundreds of millions of dollars.
3 Almost a year's worth of sales. There were no bonuses
4 this year. No new sales.

5 MR. FUTCH: So, Cindy, we done with Uncle Fester?

6 MS. BECKER: Thank you. Any questions, call Mike.

7 DR. JANOWITZ: We are way ahead of schedule. You
8 want to take a ten-minute break?

9 (A brief recess was had.)

10 MR. FUTCH: All right. Well, thank you. This is
11 a topic we've spoken about quite a bit in the past
12 couple years, and I'm happy to -- this is the passage
13 of legislation that would allow the Department to issue
14 licences in areas of radiologic technology beyond
15 radiography, nuclear medicine and therapy. The council
16 has supported it I think at least four years, five
17 years, maybe longer than that.

18 In this past year, we were fortunate to have
19 legislation under House Bill 309 and Senate Bill 376,
20 which passed. House Bill 309 takes effect on July 1st
21 of this year, and it would do almost exactly what the
22 previous versions of the legislation that you saw and
23 approved last October wanted us to do.

24 And in your -- in your packet, underneath Tab C1,
25 hopefully, is something that looks like a Chapter

1 2012-168, and I see that's it. Okay. And this is
2 the -- the law that was passed. This is House Bill
3 309, and it has everything in it to set up a special --
4 what we called a specialty technologist, and this
5 allows us to recognize a national organization, such as
6 ARRT or NMTCB, that licenses folks in areas that we do
7 not and certify them by endorsement in those areas.
8 And the -- I think the one thing that was in the
9 version of the draft legislation that you saw last fall
10 that's not in this is that version would have allowed
11 us by regulation to change the definition of radiation
12 as new technologies and new devices come into use in
13 the future. That was the one part that was not kept in
14 the bill, but it's essentially everything else we
15 wanted, and, you know, it's not that big a loss
16 because, you know --
17 MS. BONANNO: It was a nice try.
18 MR. FUTCH: -- if we do have something new that
19 pops up in the future that we need to regulate, we can
20 go back and try to ask for the law to be changed.
21 DR. JANOWITZ: What is the definition of
22 radiation --
23 MR. FUTCH: Right now -- I'll read it to you. The
24 current definition of radiation means x-ray and gamma
25 rays, alpha and beta particles, high speed electrons

1 and neutrons and other nuclear particles. So it's
2 pretty much things ionizing that you would think about.
3 So in the next tab, Tab C2, you'll see the
4 legislative implementation plan for this particular
5 law, and there are, I think, just two pages to it, and
6 basically, on the left-hand side, you'll see where it
7 says a column Directives In Bill. This is where we
8 basically took the individual mandates and instructions
9 from the legislature and broke them out individually,
10 and then as you move across the columns, it assigns a
11 timeline for different activities needed to implement
12 that mandate and then who's responsible for it.
13 There are basically two things in here that we
14 have to do. Three things, I guess. First, recognize
15 the national organization, which one are you're talking
16 about, decide which of its post primary advanced
17 specialty licenses you want to also have in Florida,
18 adopt by regulation the titles and name that will
19 appear on the Florida license for that profession and
20 then adopt a scope of practice for that profession, and
21 the legislature requires that the titles and the scope
22 of practice be consistent with the national
23 organizations. So that's where we're at now.
24 In the timeline, you can see here the first thing
25 we've done as of May 15th was meet with Mark and Gail

1 and their counterparts in MQA and discuss what changes
2 would we need to the licensing database that the
3 Department uses, discuss online applications, how that
4 needs to change in order to accommodate these new
5 license types.
6 And the second thing on the timeline is actually
7 today's meeting to discuss what national organizations,
8 which types of specialty technologists to start with
9 and the scope of practice for those, and then from
10 there it's basically as of July 1st, we can start the
11 official rule promulgation, notice of rule development.
12 If a workshop is needed, that will be held roughly a
13 month later, and then about a month after that,
14 whatever feedback you might get from that process, you
15 can initiate the actual rulemaking, which is where you
16 publish the proposed rule for comment.
17 So you can see through the timeline then if
18 every -- every one of these steps is required -- and
19 every one of them is, except for perhaps the
20 workshop -- then we anticipate having the process
21 finished by January 2013, and that's when you can start
22 accepting applications from the new people to be
23 licensed in Florida.
24 So if we move over to Tab C3, the legislation
25 specifically mentions as an example of types of

1 certification PET and CT. We deal currently with two
2 national radiologic technology organizations. One is
3 ARRT, who performs all of our State testing for all
4 three primary categories, and the other is NMTCB, who
5 we license by endorsement in the -- in the primary
6 category.
7 My computer's going to sleep. Pardon me.
8 So those are the first two that we looked at.
9 NMTCB has a smaller range of advanced and primary
10 licenses, so we put them in the book first to go over.
11 If you look at NMTCB, they basically have three
12 types of licensure beyond the basic certified nuclear
13 medicine tech. One is a nuclear cardiology
14 technologist. The second is positron emission
15 tomography, I guess, technologist, and the third one is
16 nuclear medicine advanced associate. Of those three,
17 it's really the first two that are eligible through
18 this pathway. The nuclear medicine advanced associate
19 is, I'm told, roughly at the same level of
20 responsibility as the radiologist assistant. It's a
21 position extender.
22 MS. BONANNO: It's a position extender with a
23 master's degree.
24 MR. FUTCH: Yeah, with a master's degree. So the
25 remaining two are nuclear cardiology technologist and

1 positron emission tomography technologist.
2 We've excerpted some information from the NMTCB
3 website on these couple pages here. The first one is
4 the nuclear cardiology tech. This actual paragraph of
5 information -- we really couldn't find a nice concise
6 paragraph description of what NCT was in one spot up
7 there, so we kind of cribbed it from different places
8 around the internet, so you won't actually go to
9 NMTCB's website and find that exact paragraph, but
10 that's -- that's why there's an asterisk on them.
11 Nancy's going to be here. We don't want to get in
12 trouble, but the rest of it is. So you can see the
13 exam content for the -- it's actually NCT at the bottom
14 of Page 1 there on Tab C3.
15 And then if you flip over, it shows you how many
16 of these folks there currently are in each of the
17 states, and you can see we highlighted Florida.
18 There's -- of the 682 national NCT certificates,
19 there's currently about 48 of them in Florida, and this
20 is something that you'll notice when you -- when you --
21 when we start talking about ARRT also.
22 There's really only three types of certification
23 that have any substantial numbers in the post primary
24 area, and that is mostly with ARRT, and we'll go over
25 those, but it's CT, MR and mammography. The rest of

1 them are all in the tens and a couple hundreds, so
2 they're not large numbers of people.
3 I should mention that we estimated when we did the
4 bill analysis for the legislature -- we estimated
5 approximately 600 or so people might seek the
6 certification in the first year and another 600 in the
7 second year, and we based that upon some big
8 guesstimates on how many people there were in Florida.
9 I won't go into it, but it's a big guesstimate. You
10 all could have done the same thing and probably come up
11 with a better number.
12 The second type from NMTCB is positron emission
13 tomography, and that starts on Page 3 here. You can
14 see the breakdown of their exam content and the numbers
15 there, 710 nationally and about 37 in Florida.
16 By the way, I think Nancy is one of the 48.
17 Right? For NCT?
18 MS. DeLOATCH: Yes, sir.
19 MR. FUTCH: So if you have any questions.
20 So at this point, here's why we're here and why
21 we're talking about this, for NMTCB, any way. I have
22 to write an actual regulation that says we are going to
23 recognize NMTCB as a national organization for NCT and
24 PET or one or the other or neither one or both, and
25 then I have to specify what the title is. That's

1 fairly straightforward. They've got a name. It will
2 be the same name on the Florida license.
3 And then we come to the scope of practice, and the
4 way the legislation was written it allows us to
5 simply -- since it says we have to be consistent, what
6 we can do is say, okay. The scope of practice for
7 NMTCB's NCT is found at this location on the Society of
8 Nuclear Medicine's website or whoever society, and it
9 is therefore incorporated by reference as of this date,
10 and then if I they give me permission -- if it's
11 copyrighted, I got to get their permission.
12 They put it on the Florida website with the
13 Florida regulations, and Mark and his colleagues go
14 forth and change the database, and we start taking
15 applications January 1st, and we also have to go
16 through the regulatory process and make sure that all
17 the different folks who look over our shoulder and make
18 sure we're following legislative intent feel like we
19 followed the legislative intent.
20 So from the standpoint of what I need, I've got
21 just about everything to do both of these, except for
22 the scope of practice. NMTCB is like ARRT. They look
23 to the societies for their practice standards, scope of
24 practice, whatever phrase you use for what you can do
25 in that profession.

1 And I want to make sure I get this right, Nancy.
2 In the case of PET, that's coming, we think, from
3 Society of Nuclear Medicine later this year.
4 MS. DeLOATCH: It's going to be brought to national
5 council in June. We've already -- we've already
6 alerted our representative from the southeast that this
7 is happening in Florida, and she's going to bring it to
8 the table and recommend that we start looking at the
9 very least defining the PET and coming up with a scope
10 of practice and practice standards for it as a
11 specialty for PET.
12 MR. FUTCH: And soonest that might happen would
13 be?
14 MS. BONANNO: It can probably be pulled from the
15 current scope of practice and eliminate a lot of stuff
16 that's directly just nuclear. It could be done pretty
17 quickly. It's just for -- as far as NCT, no one can
18 take that exam if they're not already a nuclear med
19 tech, so I don't think you have to do a single thing
20 about that, but x-ray techs can take the PET exam, as
21 nuclear med techs can take the CT exam, but the NCT is
22 only for people who are already nuclear med techs, so I
23 don't think we need to even include that at this point.
24 MR. TINEO: Yeah. I was going to ask that
25 question because --

1 MS. BONANNO: Nobody can take that exam unless
2 they're already a nuclear med tech.
3 DR. JANOWITZ: There should be no difference in
4 scope of practice.
5 MS. DeLOATCH: Actually, there's not.
6 MS. BONANNO: I mean, if you want to put it in
7 there only because there's a possibility that third-
8 party payers down the road are going to say, I don't
9 want to pay for that SPECT scan or the rubidium scan
10 unless it's done by somebody who's a certified NCT, but
11 I think that's not going to happen.
12 DR. JANOWITZ: What was the point of creating the
13 nuclear --
14 MS. DeLOATCH: I think -- and I may not be correct
15 in this because I just came onto the board just about
16 two years ago, and the exam was created several years
17 ago, but I think what they found was that several
18 people that work with radiology specialists that sat on
19 the board found that they were not very happy with the
20 quality of work that was being done.
21 So we kind of went along the lines the
22 accreditation on labs where they said, well, if we test
23 these people on their knowledge, that maybe it will,
24 you know -- it will kind of force the quality up to all
25 people that do nuclear cardiology and encourage them

1 and to recognize people that were -- had done all the
2 extra, gotten the extra work, you know, and just work
3 their experience in nuclear cardiology alone beyond the
4 entry level exam. I don't know that it was ever
5 intended to be anything more than a recognition. I
6 don't know that it was --
7 DR. JANOWITZ: I could see it as a recognition.
8 MS. BONANNO: That's really all it is at this
9 point.
10 DR. JANOWITZ: I don't see the accreditation
11 agencies requiring that.
12 MS. BONANNO: You never know what insurers are
13 going to do down the road.
14 DR. JANOWITZ: That's one way to eliminate nuclear
15 cardiology if they require it because nobody's
16 certified.
17 MS. DeLOATCH: Yeah. It would cripple Florida.
18 DR. JANOWITZ: You know, Florida has the most in
19 the country.
20 MS. DeLOATCH: We do, but it's still not enough.
21 MS. BONANNO: It's not very many considering the
22 number of cardiology practices. Whereas the PET,
23 that's a whole different thing, and CT is a whole
24 different thing.
25 MR. FUTCH: Okay. So --

1 MS. BONANNO: And NMAA is brand new, and I guess
2 that's going to have to come down the road the same way
3 the radiology person did.
4 MR. FUTCH: Yeah. I think that would make more
5 sense. At least, that wasn't the nuclear -- the more
6 advanced master's level person, I think you might get
7 some opposition trying to use this particular piece of
8 legislation for that purpose because it does -- it is
9 kind of an extender and steps into areas that I know we
10 never envisioned inside the -- when we did the bill in
11 the House.
12 MS. BONANNO: That all came after we started with
13 this four or five years ago.
14 MR. TINEO: That's going to have the same pushback
15 as the radiology assistant.
16 MR. FUTCH: Probably.
17 MS. DeLOATCH: I believe they do have a scope of
18 practice.
19 MS. BONANNO: Yeah. They do have a scope of
20 practice.
21 DR. JANOWITZ: So that's going to be more probably
22 a physician extender type of regulation.
23 MS. BONANNO: How was the other one --
24 MR. FUTCH: Florida radiology.
25 MS. BONANNO: The radiology.

1 MR. FUTCH: Yeah. The radiology community pushed
2 VRA.
3 MR. TINEO: And they developed what they could --
4 what they can and cannot do --
5 MR. FUTCH: Yeah.
6 MR. TINEO: -- under what is direct supervision,
7 what it was indirect supervision and all that.
8 MR. FUTCH: And that was actually -- we're getting
9 a little off the beaten path here, but for the RA, that
10 was the one exception to the registry always deferring
11 to the society for the scope of practice.
12 MS. BONANNO: Yeah.
13 MR. FUTCH: You recall we actually adopted ARRT's
14 January 2005 role delineation for our RA in Florida
15 when we first passed -- when that became law. We had
16 discussions about. That was the exception.
17 MS. DROTAR: That was -- that was, I think, in
18 coordination with ACR also to define what the role was
19 of that extender for RA.
20 MR. FUTCH: So getting back to the NCT, what I'm
21 hearing is don't try to adopt NCT at this point.
22 MS. BONANNO: No.
23 MR. FUTCH: Okay.
24 MS. BONANNO: We want the PET, and we want the CT.
25 MR. FUTCH: Yeah. The CT we'll pick from the

1 other side in a minute. PET, what do I do for a scope
2 of practice now? Because that may -- I mean, I don't
3 know what's going to happen to the regulatory --
4 There's a couple things I could do. The
5 regulatory attorneys who look at our work like
6 specificity. They hate vagueness in the regulation. I
7 shouldn't say hate. It's not personal. It's built
8 into the law adopting rules and regulations. They want
9 more and more specificity.
10 MS. BONANNO: I'm thinking --
11 MR. FUTCH: I've go to adopt something.
12 MS. BONANNO: Yeah. I'm thinking that may be able
13 to take the NMTCB and take the nuclear med tech --
14 well, we're working on one. Okay. See what we can do.
15 MS. DeLOATCH: We're working on a definition at the
16 NMTCB, and I think the same thing is they're going to
17 bring it to the NCOR.
18 MS. BONANNO: You can pull a lot of things out of
19 the nuclear medicine tech scope of practice and make it
20 into a new scope of practice.
21 MR. FUTCH: Now so I see a couple possibilities.
22 Don't do anything with PET this go round and wait until
23 this process is finished.
24 MS. BONANNO: Yeah.
25 MR. FUTCH: Okay. That's the easiest and safest

1 from my point of view, or try and put something
2 together and hit the target that they're going to end
3 up, not knowing what the target is and not having the
4 expertise to do so, but then we have you guys. So I'm
5 going to start with my position right now is probably
6 not to do anything with PET until --
7 MS. BONANNO: You hear back from them.
8 MR. FUTCH: Yeah -- somebody sticks something in
9 front of me that everyone agrees with this is a good
10 thing to use.
11 MR. TINEO: I agree.
12 MS. BONANNO: I think there may be only six people
13 in the whole country who are expert techs who have
14 taken the PET scan and passed it, so it's not -- I
15 don't think -- has anybody --
16 MR. TINEO: I don't think it's going to change
17 anything today with PET. I mean, nobody's waiting out
18 there to try to take the test to go out and get a job.
19 MS. BONANNO: But there are --
20 MR. TINEO: But there's a lot of nuclear medicine
21 techs that are ready to --
22 MS. BONANNO: To take the CT.
23 MR. TINEO: -- the CT boards to go out and get a
24 job --
25 MS. BONANNO: Yeah.

1 MR. TINEO: -- or perform those procedures. So I
2 think that's the more.
3 MR. FUTCH: Okay. And I think that will work.
4 The only -- the only possible difficulty is CT and PET
5 are specifically mentioned as examples in the
6 legislation, so it's clear that they expected something
7 to happen with those two, so we'll deal with that, I
8 guess.
9 DR. JANOWITZ: No. PET is included in the nuclear
10 medicine scope of practice.
11 MR. TINEO: Right.
12 DR. JANOWITZ: So as a temporary measure, you
13 could --
14 MR. FUTCH: But if I do that and -- see, if I
15 adopt the nuclear medicine scope and say --
16 MS. BONANNO: Then they'll think they can do a
17 thyroid scan and a bone scan, RIA.
18 MR. FUTCH: You have the people who are
19 radiographers who aren't practicing the rest of med
20 scope who then may --
21 MR. TINEO: Yeah. We got to be careful with
22 making sure we really get the scope to --
23 MS. BONANNO: Narrow.
24 MR. TINEO: -- narrow enough but not too narrow
25 that it doesn't allow flexibility. So it's --

1 MR. FUTCH: Basically, make sure it's narrow
2 enough to fit the radiographers --
3 MR. TINEO: Correct.
4 MR. FUTCH: -- keep them from getting into trouble
5 with the rest of the nuclear medicine --
6 MR. TINEO: Correct.
7 DR. JANOWITZ: You should be able to excerpt
8 what's in here.
9 MS. BONANNO: As an example. Did you already pull
10 it up?
11 DR. JANOWITZ: Yeah. I guess it will take a while
12 because it has to be approved by the NMTCB board.
13 MS. BONANNO: Yeah. The tech section has to
14 approve it and then the board society has to approve
15 it.
16 MR. FUTCH: Well, keep me in the loop there, and
17 as drafts are developed, Nancy, shoot them my way.
18 MS. DeLOATCH: Okay.
19 MR. FUTCH: And we'll send them out to the group
20 and make sure that everybody's aware of it, and if, I
21 don't know, if the opportunity presents itself somehow,
22 if miracles happen and it gets finalized before we're
23 done with whatever we're doing, we'll try and put it
24 in, I guess.
25 DR. JANOWITZ: In the best of all circumstances,

1 it could be in September.
2 MS. DeLOATCH: I was going to say it'll go before
3 the board in June.
4 DR. JANOWITZ: Before the technologist board?
5 MS. DeLOATCH: Yes.
6 DR. JANOWITZ: And the SNM board meets in
7 September.
8 MS. BONANNO: Have to start tonight.
9 MS. DeLOATCH: Actually, Cindy's already started.
10 MS. BONANNO: Oh, she's started? Okay. God love
11 her. Okay.
12 MR. FUTCH: When did we want to break for lunch?
13 Why don't we at least start into ARRT. Then we'll
14 break for lunch. Anything before we leave NMTCB?
15 Nancy, you have anything else you wanted to add?
16 MS. DeLOATCH: No. I think their position is that
17 we're working closely with American Society of Nuclear
18 Cardiology and Society of Nuclear Medicine
19 Technologists to, at the very least, have a definition
20 of NCT. They're going to work a little more towards
21 the scope of practice and practice guidelines or
22 standard guidelines for the PET portion of it, but the
23 scope of practice should come from the Society of
24 Nuclear Medicine, not from us. We can define it and
25 refer to it.

1 MR. FUTCH: All right. Well, thank you for
2 coming. You're welcome to, of course, hang around and
3 watch the rest of the fun.
4 MS. DeLOATCH: I intend to. Thank you.
5 MR. FUTCH: So moving over to Tab C4, we move into
6 the world of ARRT and ASRT. This page came to us from
7 the government relations person at ARRT. We had -- I
8 had asked a series of questions about what they offer
9 and which ones have they offered and how do they relate
10 to one another, and you'll see that these are -- these
11 are the credential titles that might appear on a
12 license. The ones that are listed as primary you'll
13 see at the top. The two that we don't currently do in
14 Florida are sonography and magnetic resonance imaging.
15 Sonography and magnetic resonance imaging are also
16 available as post primary, which is why they're listed
17 separately there in a second section, and they're
18 not -- there's no difference to the staff, Mark and
19 Gail, when it comes in. You're not going to know how
20 they came to this credential. It's just going to say S
21 or MR, and the rest are all post primary.
22 The one on the top there, cardio -- the CV,
23 there's a note down below. Basically, CV is no longer
24 issued by ARRT, but they have folks who are still
25 renewing the credential, so you might see it on a

1 wallet card. They've replaced that with CI and VI,
2 which are further down the list, cardiac-
3 interventional, vascular-interventional radiography.
4 All three of those -- there's another note down
5 below. All three of those, CV, CI and VI -- starting
6 to sound like an alphabet soup, aren't we? CV, CI and
7 VI, all three of those are covered by one practice
8 standard, which is called cardiovascular
9 interventional, and we've got some -- some notes --
10 some questions actually back to ASRT and ARRT. How
11 does one distinguish between the three inside the
12 document, or can one distinguish between the three
13 inside the document? The current answer I've got is
14 no.
15 Sonography is very similar, sonography in the
16 overall category, and then there's the two post
17 primaries, vascular sonography and breast sonography.
18 They're all covered by one practice standard, which is
19 called sonography, and I did a quick check. The word
20 "breast" does not occur in the practice standard, and
21 then, of course, CT and mammography and bone
22 densitometry. The RRA is the category we already have,
23 registered radiologist assistant.
24 And if you want to flip over to, let's see, C5,
25 you'll see the current numbers of certificates issued

1 by the country, and Florida's highlighted there in
2 yellow. If you look across the top where you see the
3 red letters in parenthesis, those are the ones that
4 match the page you were on before that actually appear
5 on a license. They've used some slightly different
6 abbreviations in the header there, like for mammo, they
7 put MAM, instead of M in parenthesis. Everything you
8 see between the two vertical lines at the top is what
9 we currently do not have in Florida. Everything
10 outside the lines we have currently in Florida.
11 And if you look at the numbers going across, you
12 can see that pretty much mammography, CT and MRI, each
13 of them has around 3,000 or multiple thousands of
14 certificate holders in the State of Florida. Now these
15 are certificates issued, and as you know, you can hold
16 multiple certificates. If you look all the way to the
17 right, there are only 21,700 people listed holding all
18 of these different kinds of certificates. If you do
19 the math, there's about 50 percent more certificates
20 than there are people, and that's part of how we came
21 up -- we ended up with 640 in here, any way.
22 So there's actually not, you know, 3,600 people
23 with CT in -- I shouldn't say that. There are 3,600
24 people with CT, but some of those may also have the MR,
25 and so if you add those two together, you get fewer

1 people. Okay. There's a lot of those three, and
2 there's not very many of the rest, as you can see.
3 DR. JANOWITZ: But there's -- if you add up the
4 nuclear therapy rads, that equals, I guess the total
5 number of tech. Right?
6 MR. FUTCH: Well, even there you may have
7 duplication.
8 MS. DROTAR: Yes. I've got all three of them, so
9 I count in each category.
10 MR. FUTCH: But, you know, that's not important,
11 except to guesstimate anything so. So here's the --
12 here's the important thing, and the happy part for me
13 is CT and MR and mammography each have their own
14 practice standard.
15 MS. BONANNO: So you just have to refer to them.
16 MR. FUTCH: Exactly.
17 MS. BONANNO: It's a beautiful thing.
18 MR. FUTCH: And they're also the three biggest.
19 So I would -- I would, you know, attempt those first, I
20 think, barring any objection or other discussion to the
21 contrary from you folks.
22 MS. DROTAR: If you look at the regulations from
23 CMS that people that are doing CT and MR and vascular
24 sonography need a certificate to demonstrate their --
25 that they are competent to do those exams, and that

1 ties into reimbursement too, so there's -- there might
2 be areas, you know --
3 MR. FUTCH: Which three were those?
4 MS. DROTAR: CT, MR and vascular sonography.
5 DR. JANOWITZ: Does mammo fall under the --
6 MS. DROTAR: MQSA.
7 DR. JANOWITZ: That requires certification?
8 MS. DROTAR: Yeah. That's pretty much covered by
9 MQSA, what they need to do and the requirements.
10 MR. FUTCH: Okay. Just to pack a few more facts
11 into your head before lunch.
12 DR. JANOWITZ: Just one other comment, though, I
13 think the vast majority of sonography technologists are
14 not certified by ARRT.
15 MR. FUTCH: There are -- there is ARDMS.
16 MS. BONANNO: ARDMS.
17 MR. FUTCH: In the -- you remember I mentioned
18 before we didn't have the legislation to define
19 radiation the way we wanted to in the future? I should
20 preface this by saying I did not directly speak to the
21 lobbyists about this particular issue, but from our
22 lobbyists, the reason we don't have that is there was
23 some opposition in the sonography community in Florida.
24 I won't say ARDMS because I don't know that, but from
25 some of the folks who said to the legislative staff we

1 have certification in sonography.
2 They were afraid we were trying to force them to
3 be licensed, and the reason is if you were to say in
4 the legislation add ultrasound to the definition of
5 radiation, that definition is used in a different part
6 of the existing law to prohibit anybody who doesn't
7 have a license to administer that radiation, prohibit
8 them from practicing.
9 Now we were never going to do that. Okay. We
10 wanted the ability to add things to the definition in
11 the future, you know, many, many years down the road
12 after the community came to us and said, hey, we would
13 like to be added to this, and it's also relevant to
14 whether or not we add sonography now because even
15 without that ability, we have the other parts of the
16 legislation which says basically you can have any kind
17 of rad tech certification you want to, so we could do
18 that. We could add sonography now.
19 Now looking at the numbers here from ARRT, you
20 probably would say, well, you know, why? There's only
21 a few of them right now. So I guess the way I would
22 recommend proceeding with sonography is let's get the
23 big ones done and let's, folks, start knowing that
24 yeah, you can add different advanced kinds of
25 certifications for radiologic technology in Florida.

1 Let the knowledge build that it's possible, and then if
2 the sonography community wants to be added to this, we
3 can do that in the next go round.
4 And that's just the thought off, you know, the top
5 of my head as the guy who has to write this because
6 sonography does have -- it does have a practice
7 standard, but it does have the built-in problem of it's
8 also got vascular and breast mixed into the middle of
9 it.
10 MR. TINEO: I'm with you because I just don't see
11 what the need is to add that as a requirement or --
12 because it's not going to do anything. People are
13 either not going to take it or not going to apply to
14 have -- I mean, there's going to be some to apply for,
15 you know, need because it's not required to have it to
16 go and perform the job, and it could make it more of
17 complaints more than anything else.
18 MR. FUTCH: If you decided you want to add
19 sonography, then you have to decide just ARRT or
20 ARDMS --
21 MR. TINEO: Right.
22 MR. FUTCH: -- also, and they have just as many
23 flavors of types of certifications.
24 MS. DROTAR: That's where it breaks down too or
25 gets more burdensome is because a lot of people are

1 using the ARRT as a basic sonography license and then
2 apply -- after they've gotten that, that takes them
3 through the next level so they can test out in physics
4 with ARDMS and go for all those different sub
5 certifications. So it can be...
6 DR. JANOWITZ: You know, I'm not sure you want to
7 tackle this right now, but I think it is an issue that
8 needs to be addressed because there are a lot of people
9 out there doing ultrasounds who are really not
10 qualified to do what they're doing. You got -- let's
11 put it this way. There's a lot of private offices
12 which are doing, say, cardiac ultrasounds, and they
13 realize, well, now I can start doing carotids, and
14 maybe I should start looking at gallbladders and
15 kidneys and that sort of stuff, and so they're taking
16 people who are trained maybe in cardiac ultrasound, and
17 then all of sudden, they're doing general type
18 ultrasound, which truthfully many of them don't know
19 what they're doing. So it may not be the highest
20 priority right now, but I think it's something that
21 should be --
22 MR. TINEO: I agree with you. I just don't see
23 how we can regulate it. I don't see how asking to be
24 in a -- going through certification is going to
25 prohibit that from continuing to happen.

1 DR. JANOWITZ: Well, if you need a license to do
2 it.
3 MR. FUTCH: Well, yeah. And the other thing to
4 keep in mind is the way this legislation is
5 currently -- was written, you -- for the areas
6 currently covered by primary radiologic technology, I
7 mean, nuclear medicine therapy and radiography, anybody
8 can go and do CT if they have a radiographer's license
9 in Florida.
10 What's different about MR and sonography is there
11 is no license issued by the state government currently
12 to do any kind of MR or sonography, so and that's just
13 a fact. So if you see, you know, oh, look. There are
14 MR licenses out there and now there's interest in
15 people wanting sonography, you know, they may start
16 coming to us at the State level.
17 I don't know. This sounds like a good place to
18 break. What did you decide?
19 MS. ANDREWS: Fridays.
20 (The meeting recessed at 11:41 a.m. for lunch.)
21 (The meeting continued at 1:16 p.m. as follows:)
22 MR. FUTCH: So we discussed ARRT and what's
23 available, and you've seen the three biggest or the
24 mammo, the CT and the MRI. Any discussion of where you
25 think we ought to start? First off, I thought about

1 this. I thought we should just adopt all of it because
2 we don't want to go through this over and over and over
3 again, but I don't know. Maybe we should just do the
4 big ones for now and save the tiny ones until somebody
5 comes and says why don't you do this.
6 DR. JANOWITZ: Have we decided to do the PET, CT
7 portion first?
8 MR. FUTCH: I think we have to do --
9 DR. JANOWITZ: CT.
10 MR. FUTCH: -- CT, the CT for nuclear medicine.
11 That's the one that most folks care about here.
12 MS. BONANNO: Right.
13 MR. FUTCH: The PET's mentioned in the
14 legislation, so when that's available, I think we ought
15 to do that one, and then beyond that, you know, the
16 next biggest are MRI and mammography. Mammography has
17 all the federal requirements, so it's not like we're
18 giving anybody the ability to do something they can't
19 already do, but that really wasn't the whole point of
20 the legislation. The point was to give them the
21 ability to reflect on their State license what they've
22 got in the national registries.
23 MS. DROTAR: If it's other than - with some of
24 these two, if it's other than if you're -- like, if
25 you're radiation therapy or if you're nu med, one of

1 the other primary modalities, the exam you're going to
2 be taking is a limited exam any way for ARRT. Right?
3 MR. FUTCH: Well, I asked them those questions,
4 and the answer I got back from ARRT was the only ones
5 that I know of were MR and sonography, and they said
6 there was no difference in --
7 MS. DROTAR: Oh, okay.
8 MR. FUTCH: -- what they're giving folks and what
9 appears on their license. I used to think that there
10 was two different ways of getting bone densitometry,
11 but you saw the response I got from ARRT.
12 MS. DROTAR: Yeah.
13 MR. TINEO: No. I think it's a full -- full exam.
14 MS. DROTAR: But we're limiting the license to
15 what they can do in Florida. Right? If they're --
16 MR. FUTCH: Well, I wouldn't say we're -- I
17 wouldn't want to think we're limiting the license --
18 MS. DROTAR: Okay.
19 MR. FUTCH: -- I mean, in any way, shape or form.
20 It's --
21 MS. DROTAR: Well, what I mean is, like, when
22 you're a -- if you're a radiation therapist and you've
23 got the CT, you're only going to be doing CT as related
24 to radiation therapy.
25 MR. FUTCH: Under current law, yeah. If you were

1 in Florida and you're a radiation therapist, you can do
2 CT but only for simulation purposes related to
3 radiation therapy. You couldn't do diagnostic CT as a
4 radiation therapist, unless you went and got ARRT
5 certification and then came to Florida and we gave you
6 that CT certification. Then you could do diagnostic
7 CT.
8 DR. JANOWITZ: Do it outside of radiation therapy.
9 MR. FUTCH: You could with the new certification,
10 but not without it.
11 DR. JANOWITZ: Same thing with nuclear medicine.
12 MR. TINEO: They have to pass the exam, and then
13 you just apply for your license. Correct?
14 MR. FUTCH: Maybe I didn't understand the
15 question. They're going to the national registry and
16 getting whatever they want, and then they're coming
17 back to Florida and saying I want to do this in
18 Florida. So we're not sending anybody to exam for
19 Florida's purposes. Was that the question?
20 MS. DROTAR: Sort of. Okay. Because -- actually,
21 one of the other things is when we're looking at these,
22 that it's like now JRC has accreditation for MR
23 programs, and they've also started one for basic
24 machine licensing which is separate, but if their --
25 you know, if they develop other accrediting --

1 accredited programs, educational programs, then, you
2 know, that could be a place for certification, you
3 know. I don't know what I'm saying, but, you know, to
4 look for -- to not limit maybe what we're really
5 looking at if it's a certification that somebody can
6 get. They're going to be looking for that specialized
7 certification.
8 MR. TINEO: I don't think the State is trying to
9 certify people. They're just trying to --
10 MS. DROTAR: No, not them -- not for them to
11 certify, but the technologists are going to look at why
12 can't I get -- if we can -- if I can get a license for
13 CT, why can't I get one for quality management or one
14 of the other certifications?
15 MR. FUTCH: And that may happen.
16 MS. DROTAR: I mean, it's just the other side.
17 MR. FUTCH: That's an argument to adopt all of it
18 as once or as close as possible in time. I don't know
19 what people may want or may come to us for.
20 MR. TINEO: Is there a cost associated with all
21 this? I can imagine that this is labor intensive.
22 MR. WHITTEN: There's an IT component. There's
23 the solution for that. We're working on that. There
24 are so many fields you can put on a physical license,
25 only so many fields, and there is staff time, of

1 course, but we're going to absorb.
2 MR. FUTCH: The legislation proposes to charge $45
3 per application.
4 MS. CURRY: And it's strictly endorsement, so it's
5 not a lot of more -- it's not a lot of time spent on an
6 application.
7 MR. FUTCH: I think 45 is the current endorsement
8 fee.
9 MR. TINEO: So if the person wants it, they're
10 just going to have to pay the additional $45.
11 MR. WHITTEN: It's really a checkbox and a check.
12 MR. TINEO: Additional revenue. I mean, my
13 position is let's just take as many as we can, but
14 start from the CT portion of it and start implementing
15 all of it. I mean, there's no reason why not.
16 MR. FUTCH: Well, except for the scope of practice
17 issue on a couple of them.
18 MR. TINEO: Right. Well, whichever one have
19 developed the scope of practice, we just implement
20 those as we go down the list and then...
21 MR. WHITTEN: That's what I would recommend, just
22 do it as a phased approach based on what you can notice
23 as far as rulemaking. Start with doing the
24 endorsements for those where James can immediately
25 start the rulemaking. Then we go down the path. As we

1 can notice a new development of rules, we start
2 bringing more people into the fold.
3 DR. JANOWITZ: How do we define a national
4 accrediting organization?
5 MR. FUTCH: A national organization is -- it's in
6 the existing law. A national organization means a
7 professional association or registry approved by the
8 Department that examines, registers, certifies (insert
9 your group) or approves individuals or educational
10 programs related to operative sources...
11 DR. JANOWITZ: So the Department can decide.
12 MR. FUTCH: Yeah. That's the key part. Yeah.
13 And we also have that in the legislation where it
14 refers to the certification types. We have an approval
15 process there also. So first approve the -- I mean,
16 it's not going to be a two-step process. We're just
17 going to do it, but there are two different places in
18 the law that gives us the ability as the Department to
19 decide what it is.
20 DR. JANOWITZ: Because I remember we had an issue
21 with some RT schools that were not approved a few years
22 ago, and they sued. Didn't they sue or something?
23 MR. FUTCH: Do you remember that?
24 MS. CURRY: Remember Dade Medical?
25 MR. FUTCH: Oh, God.

1 MS. CURRY: How can you forget?
2 MR. FUTCH: Well, he said sue. Yeah. That's not
3 a problem right now.
4 MS. CURRY: At the time it was.
5 MR. FUTCH: Yeah. Yeah. We're recording. Okay?
6 So we'll leave it at that for now. They're accredited
7 now. But that was -- that was...
8 All right. Well, I still have -- going to go
9 forth, talk to NMTCB, talk to ARRT. For whichever ones
10 of these we can develop the language, we'll put the
11 language together, and hopefully, we'll be able to show
12 that to you sometime in the next month or so.
13 Let me show you -- the next tab, C6, is an example
14 of a license issued by MQA. This is close to being a
15 real license. We don't normally put basic x-ray
16 machine operator and general radiographer on the same
17 license, which is why this one's in here. This is one
18 that we had to correct but this -- the upper left-hand
19 portion here is the wallet -- the wall certificate, and
20 then you see the wallet card in the upper right-hand
21 corner, and I wanted to show you this so you can see
22 how much real estate we've got for spelling out license
23 types.
24 The next page is essentially the same thing but
25 for a different profession. This is for a clinical lab

1 technologist, and you can see in the middle there where
2 it starts talking about qualifications, and then if you
3 look at the wallet card, there's the same thing on the
4 left-hand side of the wallet card. Clinical labs is
5 the profession used by -- or regulated by MQA that has
6 after us the most types of things on a license that you
7 can list, and so this person is a hematology
8 technician, a microbiology technician -- I can't even
9 read the next one.
10 MR. TINEO: Immunohematology.
11 MR. FUTCH: And so forth and so on. So I expect
12 that, as Mark said, there may be some maximum limit
13 here in the paper itself, and once we exceed that, I
14 don't know. I guess we don't list the license anymore.
15 MR. TINEO: It's going to be economics, how many
16 people are going to pay the $40 per.
17 MR. FUTCH: Oh, yeah, that too. Well, Kathy will.
18 I mean, she's got... I should ask you how many of
19 those other ones you don't have that are already on the
20 Florida license.
21 MS. DROTAR: Actually, I've only got three, yeah.
22 MR. FUTCH: Okay. And then the flip side of this
23 is what it looks like now on the license that we give a
24 person but the license on the online site, the
25 verification. So this is what I would expect it would

1 like for rad techs. Everything that's new is going to
2 be looked at as a qualification, and up at the top, it
3 will say Certified Radiologic Technologist, instead of
4 Clinical Lab Technologist.
5 You know, we're talking about multiple national
6 organizations also. I mean, right now it's pretty
7 simple. ARRT has these. NMTCB has these other ones.
8 They don't really overlap. We don't have CT for both
9 organizations. We start talking about ARDMS and
10 sonography, we've got sonography from two different
11 organizations. I guess that's just another thought, if
12 we go to that point.
13 MS. BONANNO: There's two nuclear medicine ones
14 too.
15 MR. FUTCH: Yeah, but we don't -- and that's an
16 important distinction. We don't currently -- I can
17 give you an endorsement license for ARRT in nuclear
18 medicine or I can give you an endorsement license from
19 the license itself. It doesn't indicate which way you
20 came.
21 MS. BONANNO: Because some people got both.
22 MR. FUTCH: Yeah. So I would assume we would keep
23 that the same. We don't need to start listing ARRT
24 after everything.
25 MS. DROTAR: No. You want the credential from the

1 people that are actually credentialing you in it. If I
2 were looking for documentation for a new instructor,
3 I'd want the ARRT card, the same as you wouldn't give
4 transfer credit information on a, you know, another
5 college.
6 MR. FUTCH: Well, Mark and Gail and their staff
7 will check all the wallets cards.
8 MS. CURRY: And those will all be in I-center too.
9 There will be a scan document in I-center, so we'll
10 always have record of that.
11 MR. FUTCH: Document imaging system. It needs to
12 be tracked.
13 MR. RICHARDSON: James, on this license
14 verification where it says profession, where would the
15 BMO be? Would they be radiologic technologist?
16 MR. FUTCH: No. There's is basic x-ray machine
17 operator.
18 MR. RICHARDSON: So very specific.
19 MR. FUTCH: And they're not eligible for any of
20 these at this point, unless the national registry has
21 changed their policies and started granting them.
22 MS. BONANNO: I don't know if that will ever
23 happen.
24 MR. FUTCH: But yeah. Where it says clinical lab
25 technologist, it will say basic x-ray machine operator.

1 All right. Well, the rest of these C tabs are, I
2 think, really not needed. These are the actual scopes
3 for each of the ARRT credentials that you just saw.
4 The cardiovascular one is underneath C8, and in your
5 leisure time, you can flip through and see if you can
6 divine where CI and VI are separated out. I couldn't
7 find it.
8 And then if you flip ahead to sonography, the same
9 thing. They actually list -- ASRT actually lists some
10 of the other registries. Like, underneath sonography
11 on Page S-5, sonography is in the C11 tab. You'll see
12 they mention not only ARRT, they mention ARDMS, so they
13 are not registry specific, and those are some of the
14 titles that ARDMS is using, RVT for vascular
15 technology; RDCS for registered diagnostic cardiac
16 sonographer; and then CT.
17 So any further discussion on that? I'll move on
18 to the D tab. I appreciate the discussion. If you
19 have any other thoughts, talk to your societies,
20 facilities. Want to make anything apparent to me about
21 what is good and what is not good, call me up, e-mail
22 me.
23 Okay. May I move on to Tab D?
24 DR. JANOWITZ: Sure.
25 MR. FUTCH: Okay. Tab D, the registry, every once

1 in a while, will update the content specifications for
2 an examination. I'm talking mostly ARRT. Most of
3 these exams, I think all the exams, except for basic,
4 are 200 questions graded, and they have certain subject
5 areas, you know, radiation protection, image production
6 and evaluation, so forth and so on, and these things
7 will change over the years. They just modified
8 radiography a little while ago, put in more
9 digital-focused questions, took out some film-focused
10 questions.
11 They're very careful to always keep the number of
12 questions the same. There's a lot of statistics, and,
13 I guess, a little psychology that goes into the design
14 and vetting of these exams to make sure that they
15 actually test what they're suppose to test. I'll be
16 the first to admit I'm not qualified to explain a
17 fraction of it.
18 But I have been talking to some of the folks
19 because what ARRT is doing next year is they're
20 changing the number of questions -- they call it the
21 cut score -- that an applicant must get correct in
22 order to get a passing score on the exam.
23 A passing score on the exam is referred to as a 75
24 scaled score. There are -- since we have time, I'll
25 digress for a moment. If somebody knows more than

1 this, jump right in. Okay? But there are multiple
2 forms of an exam in circulation at any given point in
3 time. There's a large question bank. If I go and take
4 a test today in Tampa and Kathy goes and takes the test
5 tomorrow in Jacksonville, I'm not necessarily going to
6 see the same questions that Kathy saw on the test. I
7 may have taken one form of the exam. She took another
8 form of the exam. Hers may be more difficult than
9 mine.
10 There are certain questions that are present in
11 all of the forms of the test that are anchor questions
12 that ARRT uses to rate the relative difficulty of
13 whatever forms of the exam, so that if they say I got a
14 passing score and it was 75, which is a passing score,
15 even though she may have answered fewer questions than
16 me because it was a more difficult exam, she also
17 earned a 75 on the test. So there's -- there's the
18 actual number of questions you got correct, and then
19 there's the score that's reported as the scale score.
20 The scale score hasn't changed from a 75 since the
21 inception of the current system back in the early
22 1980's, I think they said it was. It hasn't changed in
23 Florida at all.
24 In our regulation, we picked a passing score is
25 the 75. Next year to get a 75, depending upon which

1 particular form of the exam you're talking about, let's
2 say the average form, you will have to answer six more
3 questions correctly to get that 75 next year than you
4 do currently, and those six questions out of 200 works
5 out to roughly 3 percent. So another way of thinking
6 about it is if they didn't make this change -- that's
7 not the way.
8 DR. ATHERTON: You'd have to pass 78 percent.
9 MR. FUTCH: No. It's the other way. 73 or 2,
10 somewhere in that vicinity would be passing in the
11 new -- in the old scheme as reflected in the new
12 scheme. It's really easy to get this stuff wrapped
13 around the axles. Okay. Take this to heart. You have
14 to get more questions right next year than you do
15 currently. So even though the numerical score isn't
16 changing, in order to get it, you have to do slightly
17 better.
18 So we're bringing this to you today because -- not
19 that I anticipate any, you know, questions or issues or
20 something like that, but the first person next year who
21 earns, say, a 74 and finds out about any of this may
22 come back to us and say, well, what did you do that
23 for? And we're going to, say, hopefully, because we
24 talked to our council, and they suggested that we stay
25 the same as the national registry, which is a 75 scaled

1 score. I don't know if you'll actually say that, but
2 I'm hoping you'll say that.
3 MS. DROTAR: On the registry site, they have a
4 PowerPoint that's just gone up recently that explains
5 the whereas and wherefores and how the score actually
6 stays the same.
7 And I was actually on a committee that we were out
8 there in October or November, and we actually took the
9 registry and looked at the questions, and there were 15
10 people, different managers, educators, people that do
11 the hiring, and what we really looked at and what the
12 registry was looking at was -- because the surveys that
13 they've gotten back were questioning that the people
14 that were passing the low scores that were actually
15 passing the exams, if they really knew what they were
16 doing and had the registry gotten dumber over the
17 years.
18 And so they -- but they look at this about every
19 five years, and when -- you know, through multiple
20 processes. So it's not just one process, and what we
21 looked at in taking the registry was -- or looking at
22 some questions was should a student know this, and
23 should a basic entry level student or graduate know
24 this? And if so, what -- what's the percentage of them
25 getting that question correct?

1 And what we all found was that through -- that
2 through that process -- and it was taken to the
3 registry board and presented -- that the -- even though
4 the score, the passing score stays the same, that the
5 raw score did need to be adjusted, and they've done
6 this with other -- in other disciplines, and it doesn't
7 really -- what it does is to help ensure the integrity
8 of the exam, that the people that are taking it are
9 qualified and competent to be in that profession so...
10 MR. FUTCH: Thank you, Kathy.
11 DR. JANOWITZ: Can people apply for license if
12 they have not passed the exam?
13 MR. FUTCH: Well, they can certainly apply.
14 DR. JANOWITZ: Isn't it a requirement?
15 MR. FUTCH: Yeah. They're only going to become
16 licensed in two ways. Either they're going to be
17 licensed by exam where we sent them to the exam or by
18 endorsement, and one of the requirements -- you're
19 correct -- for endorsement is if you're going to use
20 another license, it has to have substantially
21 equivalent requirements to ours, which includes passage
22 of the exam.
23 DR. JANOWITZ: But our exam is separate from
24 these.
25 MR. FUTCH: It's the same. Yeah. We've used

1 ARRT's exam as our State exam since 1980 -- well, since
2 the beginning.
3 DR. JANOWITZ: So that's the reason this is coming
4 up.
5 MR. FUTCH: Yeah.
6 MR. RICHARDSON: Does anybody take the State exam?
7 MR. FUTCH: Well, how would you answer that
8 question?
9 MS. CURRY: Well, they do, especially the people
10 that -- it's kind of funny. If they apply for a
11 temporary coming out of school, they'll take the ARRT
12 exam, and if they've applied with us, we give them
13 their regular certificate based on passing the ARRT,
14 and they don't have to take it twice, one for national,
15 one for State.
16 MR. FUTCH: But they do have to pass --
17 MS. CURRY: They do have to pass the exam.
18 MR. FUTCH: So if you come to us as an exam
19 candidate, we -- and I defer to you guys because I
20 haven't seen the nuts and bolts of it for about seven
21 years now, but you're going to submit them to ARRT's
22 website mechanism so they can go take the test with
23 ARRT, and then we're going to --
24 MS. CURRY: Correct.
25 MR. FUTCH: -- license them based upon that

1 result.

2 MR. RICHARDSON: But they'll only have a State

3 certification, not a national.

4 MR. FUTCH: Yeah. That's an important

5 distinction.

6 MR. RICHARDSON: But does anybody do that? That's

7 my question. If they're taking the same test --

8 DR. ATHERTON: Yeah. Why would they do that?

9 MS. CURRY: Very few. We have very few that --

10 because most people coming from out of state come in by

11 endorsement because they have the national. They have

12 the ARRT, and we hardly ever have anybody that applies

13 just to take the State exam. They usually apply for --

14 MR. FUTCH: They got to take it for both.

15 MS. CURRY: Right.

16 DR. JANOWITZ: And when they take the State exam,

17 you usually use the passage of the ARRT as the criteria

18 for passing the State.

19 MR. FUTCH: Yeah.

20 MS. CURRY: They're our national vendor, yes.

21 MR. FUTCH: They have a contract with ARRT to use

22 their testing services for your services.

23 DR. ATHERTON: So should there ever be an issue

24 where this will come up, I mean?

25 MR. FUTCH: I wouldn't put it past -- let me put

1 it to you this way. They may start with ARRT first,
2 and ARRT will probably tell them to go pound sand.
3 Then they'll come to us, and since they're probably
4 practicing in Florida, that's mostly what they care
5 about is the State license, and I don't want to -- I'm
6 not saying this is going to happen. What I'm saying is
7 it would be -- it would be best if we stayed with the
8 number we had all these years and that the rest of the
9 country is using.
10 There was one state that asked quite a few
11 questions, I guess, of ARRT about this change, kind of
12 like I did, and then they decided to do the same thing
13 also, which was stay with the 75 that ARRT is using.
14 DR. JANOWITZ: Do you ever get the raw score for
15 the ARRT exam, or do you always get the, what is it,
16 scale score?
17 MR. FUTCH: No. They only report the scale score
18 test for -- the only raw score we get is for limited
19 scope, which is handled differently. So we're not
20 going to know. This is the beauty of this. The
21 regulation doesn't even need to be changed because the
22 regulation folks is on the scale score, not on the test
23 score.
24 MS. DROTAR: And if they do get a 74, it's not
25 because they got one question wrong. It's because each

1 of them has a different rating, and our rating and the
2 Z-Score and all of that gets thrown in psycho
3 symmetrically so that it's not any one thing, and it's,
4 you know, and if there's five different parts to the
5 exam and they can do not so well, they can do below a
6 75 or 7.5 in one area and make it up in another, so
7 it's the average of all five portions of it.
8 DR. JANOWITZ: Does the -- I don't know if the
9 website available you have the requirements for
10 licensure clearly state what the requirement is for
11 passage.
12 MR. FUTCH: Yeah.
13 DR. JANOWITZ: So I think we should just endorse
14 the current way.
15 MS. DROTAR: I agree.
16 DR. JANOWITZ: Unless anyone else wants to discuss
17 it.
18 MR. FUTCH: And the question would be to retain
19 the 75 scale score, as we currently are, in the future
20 years.
21 DR. JANOWITZ: All right. So do we have a motion
22 for vote?
23 MR. TINEO: Yeah. Move.
24 MS. BONANNO: I so move.
25 MS. DROTAR: Second.

1 DR. JANOWITZ: All in favor?
2 Aye.
3 MS. BONANNO: Aye.
4 MR. BURRESS: Aye.
5 MS. DROTAR: Aye.
6 DR. ATHERTON: Aye.
7 MR. RICHARDSON: Aye.
8 MR. TINEO: Aye.
9 DR. JANOWITZ: It's unanimous.
10 MR. FUTCH: That's pretty much it for everything
11 that is known.
12 DR. JANOWITZ: Is there any old business or any
13 council members that have a new issue they want to
14 bring up?
15 MS. BONANNO: I brought this up to James, but I
16 guess everybody should hear it because I had a
17 technologist ask me what about PEM imaging, which is
18 PET mammogram, basically, and, you know, the mammogram
19 standards are very high, but yet, you don't want a
20 mammo tech doing a PET scan, so he just wanted to know
21 who could do it in their particular site, which is an
22 outpatient center, and they just bought a PET machine.
23 DR. JANOWITZ: My understanding is it would be a
24 nuclear medicine tech.
25 MS. BONANNO: Thank you. That's what I want to

1 hear.

2 MR. FUTCH: Yeah. Since I got the regs in front

3 of me and the statute too and I've answered this one a

4 couple times for, I think, two facilities that I know

5 of that asked me, if you go to 468.302(3)D, this

6 essentially is a major portion of the scope of nuclear

7 radiography.

8 It says "a person holding a certificate as a

9 general radiographer may not perform nuclear medicine

10 and radiation therapy procedures except as provided in

11 this paragraph," and then I won't read you the rest of

12 the paragraph, but that speaks to the whole radiation

13 therapy assistance that we dealt with back in 2001 or

14 so and all that. It doesn't have anything to do with

15 nuclear medicine. So essentially, that first sentence

16 right there says it all.

17 DR. JANOWITZ: So I guess if they took the PET

18 exam.

19 MR. FUTCH: Yes. Thank you.

20 MS. BONANNO: You can take the PET exam, but that

21 would be an awful lot of work just to do mammos.

22 MR. FUTCH: I said the same thing myself to a

23 couple facility medical physicists asking me this

24 question a couple years ago and pointed out to them how

25 beneficial that would be if this law would pass.

1 MS. BONANNO: I think it's being reimbursed
2 privately. I don't know if Medicare's paying for it.
3 DR. JANOWITZ: But I'm not sure -- we have one,
4 but I don't know.
5 MS. BONANNO: There's one in St. Pete. That's who
6 asked me.
7 MR. FUTCH: When I talked to NMTCB last year about
8 this and then again this year, somewhere along the way,
9 you know, that number of certified PET folks in Florida
10 the list of 47 or 48 and then 6 or 700 nationally, I
11 don't think there was any radiographer who was
12 certified in PET in Florida.
13 MS. BONANNO: I don't think so either.
14 MR. FUTCH: I get the impression it's not that
15 common.
16 MS. BONANNO: I think last time I asked Danny how
17 many x-ray techs passed the PET it was two or three.
18 MS. DeLOATCH: Yeah. It's less than a handful, it
19 truly is, nationally.
20 MR. FUTCH: I guess there's -- just not everybody
21 is anxious to use a radiographer for nuclear medicine
22 yet.
23 MS. BONANNO: Not too many small places have a PET
24 scanner.
25 DR. JANOWITZ: But we do have a lot of dual-

1 certified RTs and NMTs.
2 MS. BONANNO: Yeah. 4 or 500 nationwide that are
3 sill certified. There used to be more, but they
4 started retiring.
5 MR. RICHARDSON: And there are nuclear medicine
6 programs that will take RTs an additional year, so
7 there's a mechanism if somebody wanted do that.
8 MS. BONANNO: They do that at Florida Hospital.
9 DR. JANOWITZ: Are there any other issues? Then
10 we can discuss the next meeting.
11 MR. FUTCH: Ms. Brenda?
12 MS. ANDREWS: I have calendars in the very back
13 for October and November, and we need to come to an
14 agreement on, between those two months, a date.
15 MR. FUTCH: Traditionally, of course, we've
16 focused on October.
17 MS. ANDREWS: But I do have a request that we look
18 closer at November because we have a council member who
19 would not be able to make in November (sic) and really
20 wants to, and November would be better for them.
21 DR. JANOWITZ: I can tell you I am away the first
22 two weeks in November.
23 MS. BONANNO: I'm away the week of the 21st in
24 October.
25 DR. JANOWITZ: Actually, I will be leaving the

1 27th of October.

2 MS. BONANNO: When do you get back? Are you back

3 by the 12th?

4 DR. JANOWITZ: I'm coming back on the 14th.

5 MR. TINEO: The following week is Thanksgiving,

6 isn't it?

7 MR. FUTCH: So that's not a good week to use. I

8 think we're rediscovering why we usually pick early

9 October. Yeah. Any problem with the first or second

10 week of October that anybody has?

11 MS. DeLOATCH: Southeast Chapter is -- it's in

12 September.

13 MS. BONANNO: Okay. No problem with that.

14 MR. FUTCH: All right. Well --

15 MS. DROTAR: So what? The 1st through the 8th, is

16 that what we're looking at?

17 MR. FUTCH: It's Tuesday, so the 2nd or 9th. Is

18 the 16th just as good or is that --

19 MS. BONANNO: Yeah.

20 MR. FUTCH: So we'll have to send something out

21 and look as those three with the rest of the members

22 that couldn't be here and see what they say.

23 MS. ANDREWS: Okay.

24 DR. JANOWITZ: I guess we're ready to adjourn.

25 MR. TINEO: Move to adjourn.

1 MS. DROTAR: Second.
2 DR. JANOWITZ: Well, thank you, everyone.
3 (The meeting concluded at 1:56 p.m.)
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1 C E R T I F I C A T E

2 STATE OF FLORIDA

3 COUNTY OF PASCO

4

5 I, Penny M. Appleton, Court Reporter for the

6 Circuit Court of the Sixth Judicial Circuit of the State of

7 Florida, in and for Pasco County,

8 DO HEREBY CERTIFY, that I was authorized to and

9 did, report in shorthand the proceedings and evidence in the

10 above-styled cause, as stated in the caption hereto, and

11 that the foregoing pages constitute a true and correct

12 transcription of my shorthand report of said proceedings and

13 evidence.

14 IN WITNESS WHEREOF, I have hereunto set my hand in

15 the City of Wesley Chapel, County of Pasco, State of Florida

16 this 30th day of May, 2012.

17

18

19

20

21

22

23 ______________________________

Penny M. Appleton

24 Court Reporter

Notary Public

25

A

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abbreviations 59:6
ability 62:10,15 66:18,21 71:18
able 15:2,7 16:5 21:25 52:12 55:7 72:11 89:19
about 5:16 10:1,2 13:21 13:21 16:7,14,16,19,24 17:3 18:8 22:18,19 26:1 26:13,14,17 28:4,9 29:6 33:7 34:13 37:13,23 38:7 39:11 41:2,16 42:13 44:19,21 45:15 45:21 46:21 47:20 48:15 51:16 57:8 59:19 61:21 65:10,25 66:11 73:2 74:5,9 76:20 79:1 79:6,21 80:18 82:20 84:5,11 86:17 88:7
above-styled 92:10
absorb 70:1
absorbing 21:6
accepting 42:22
access 29:1
accidents 11:6
accommodate 17:22 42:4
accreditation 48:22 49:10 68:22
accredited 69:1 72:6
accrediting 68:25 71:4
ACR 51:18
across 41:10 59:2,11
acting 11:20 12:3,8,9
activities 41:11
activity 36:13
actual 22:3 42:15 44:4 45:22 76:2 78:18
actually 15:11,13 17:17 18:11 23:1,2 27:4 28:2 32:18 42:6 44:8,13 48:5 51:8,13 56:9 58:10 59:4 59:22 68:20 73:21 75:1 76:9,9 77:15 80:1,5,7,8 80:14 89:25
add 17:8 56:15 59:25 60:3 62:4,10,14,18,24 63:11,18
added 62:13 63:2
additional 70:10,12 89:6
addressed 64:8
adjourn 90:24,25
adjusted 81:5
administer 62:7
Administrator 2:9,9
admit 77:16
adopt 41:18,20 51:21 52:11 54:15 66:1 69:17
adopted 51:13
adopting 52:8
advanced 41:16 43:9,16 43:18 50:6 62:24
Advisory 1:3 2:3
affect 11:14
afraid 8:4 19:13 62:2
after 22:21 25:10 28:15 42:13 50:12 62:12 64:2 73:6 74:24
again 4:25 9:21 28:21 32:22 35:8 66:3 88:8
against 34:8
agencies 49:11
agenda 13:12
ago 36:15 37:12,14 48:16 48:17 50:13 71:22 77:8 87:24
agree 53:11 64:22 85:15
agreed 27:12
agreement 89:14
agrees 53:9
ahead 5:25 6:5 18:21 39:7 76:8
air 8:5 13:2,3
airport 1:13,14 6:24 17:20
Alamos 21:18 23:23 25:6
alarm 25:19
alarms 20:5
Albert 4:5
Alberto 2:7 19:6
alerted 47:6
all 3:3 6:9,19 7:7 8:2 9:20 11:20 12:8,14 13:14 14:5 16:19 17:9,25 19:19 20:15,17 21:10 23:15,17 25:10 26:9,21 27:23,25 29:3,7 30:8 31:14,16,19 33:7,25 37:2,4,25 38:15,16 39:10 43:3,3 45:1,10 46:16 48:24 49:1,8 50:12 51:7 55:25 57:1 57:21 58:4,5,7,18 59:16 59:17 60:8 64:4,17 66:1 66:17 69:17,20 70:15 72:8 75:7,8 76:1 77:3 78:11,23 81:1 84:8 85:2 85:7,21 86:1 87:14,16 90:14
allow 39:13 54:25
allowable 35:23 36:23
allowed 40:10
allows 40:5 46:4
almost 10:12 39:3,21
alone 49:3
along 48:21 88:8
alpha 40:25
alphabet 58:6
already 32:15 47:5,5,18 47:22 48:2 55:9 56:9 58:22 66:19 73:19
also 5:12 6:8 8:5,8,16 11:11,24 19:16,16 21:17,18 22:9 24:15 25:9 29:12 41:17 44:21 46:15 51:18 57:15 59:24 60:18 62:13 63:8 63:22 68:23 71:13,15 74:6 78:16 84:13
Although 25:18
always 31:7 51:10 75:10 77:11 84:15
am 5:9,11 89:21
America 15:12,15
American 56:17
amount 38:16
an 7:6 8:14 12:8 15:16 16:4 17:12 23:14 25:19 26:17 28:20 35:7 42:25 44:10 45:22 50:9 55:9 58:6 64:7 69:17,22 70:5 71:14,20 72:13 74:15 74:17,18 77:2,21 78:2 82:18 83:4,23 86:21 87:21 89:6,13
analysis 45:4
anchor 78:11
and 3:10,11,14,17 4:11 5:1,2,10,12,14,17 6:4,5 6:6,8,8,8,17,19,24,25 7:12,16,20,21,23 8:5,9 8:9,11,16,24 9:7,9,10 9:17,24,24 10:14,15,15 11:1,22,23 12:3,10,12 13:3,18,20 14:1,8,20,24 14:25 15:2,4,5,8,16,23 15:23 16:1,3,5,6,9,14 16:14,25 17:4,5,11 18:1 18:5,6,13,14 19:6,12,17 19:19,22,24 20:1,2,4,5 20:8,8,20,22,24,25 21:4 21:6,7,9,17,19,21,22,25 22:7,9 23:18,19 24:2,6 24:13,21,24 25:6,7,9,11 25:20,23 26:7,19,25 27:1,5,11,12,15,19,20 27:23 28:3,4,8,16,17,18 28:21 29:3,3,6,8 31:5 31:20 32:5,7,8,9,15,20 33:5,10,12,14,15,17,22 34:7,9,11,17,18,19,19 34:20,21,21,24 35:2,5,9 35:23 36:7,15,16,17,20 36:21,22,23 37:1,2,2,14 37:24 38:5,8,9 39:12,15 39:19,21,22,24 40:1,1,3 40:4,7,8,12,15,20,24,25 41:1,1,5,5,8,9,10,12,18 41:19,20,21,25 42:1,1,6 42:9,9,13,18,21 43:1,4 43:9,15,25 44:9,15,17 44:19,24,24,25 45:1,6,7 45:10,13,14,15,20,23 45:24 46:3,3,8,10,13,13 46:14,14,15,16,17 47:1 47:7,8,9,10,12,15 48:14 48:16,25 49:1,2,23 50:1 50:1,9 51:3,4,7,8,24 52:8,9,13,16,19,22,25 53:1,2,3,14,18,23 54:3 54:4,14,15,17 55:14,16 55:19,20,20,22,23 56:6 56:18,21,24 57:2,6,9,9 57:10,14,15,17,18,21 58:1,5,6,9,10,16,17,19 58:20,21,21,24 59:1,11 59:12,15,20,25 60:1,12 60:13,13,18,23,23,25 61:4,9 62:3,12,13,23 63:1,4,8,16,16,22 64:1 64:4,12,13,14,15,15,16 65:3,7,8,10,12,14,22,23 65:24 66:2,2,4,5,15,16 67:4,5,5,8,22 68:1,4,5,5 68:12,15,16,17,23 69:15,25 70:4,11,14,20 71:13,22 72:11,16,19 72:21 73:1,2,7,11,11,13 73:22 74:2,9,15 75:6,6 75:8,19,21 76:4,5,6,8 76:13,16,21 77:4,6,6,6 77:12,14 78:3,4,4,14,18 79:4,21,22,23,24 80:5,5 80:7,8,9,9,11,11,16,18 80:19,20,22,24 81:1,2,3 81:5,6,9,18 82:12,14,19 82:20,23 83:12,16 84:2 84:3,5,8,12,24 85:1,1,2 85:3,4,5,6,18 86:18,22 87:3,3,10,11,14,24 88:8 88:10 89:1,5,13,13,19 89:20 90:21,22 92:7,8,9 92:10,11,12
Andrews 2:10 4:2,2,15 5:24 6:1,16 18:8,13,15 65:19 89:12,17 90:23
animal 31:24
annual 17:12 29:13 35:24
another 31:23,23 45:6 57:10 58:4 74:11 75:4 78:7 79:5 81:20 85:6
answer 32:23 58:13 67:4 79:2 82:7
answered 78:15 87:3
anticipate 42:20 79:19
anxious 88:21
any 4:16,21 6:2 9:4,5,8 9:11 13:23 16:2 17:6,7 26:23 30:1 37:19,21 39:6 44:23 45:19,21 59:21 60:20 62:16 65:12,24 67:2,19 75:19 76:17,19 78:2 79:19,21 85:3 86:12,12 88:11 89:9 90:9
anybody 9:11 17:25 22:19 27:5 53:15 62:6 65:7 66:18 68:18 82:6 83:6,12 90:10
anymore 36:3 73:14
anyone 85:16
anything 5:20 10:1 18:9 21:19 22:19 23:11 26:2 37:22 49:5 52:22 53:6 53:17 56:14,15 60:11 63:12,17 76:20 87:14
apparent 76:20
apparently 25:10
appear 32:5 41:19 57:11 59:4
appears 67:9
Appleton 1:19 92:5,23
applicant 77:21

applicants 16:22
application 14:17,19 15:2 34:18 70:3,6
applications 13:17 14:24 42:3,22 46:15
applied 15:4 82:12
applies 83:12
apply 17:4 63:13,14 64:2 68:13 81:11,13 82:10 83:13
appoint 12:5,6,6
appointed 12:16
appointment 11:19
appreciate 76:18
approach 70:22
appropriate 33:3
approval 4:13 71:14
approve 4:18 55:14,14 71:15
approved 13:17 15:17 17:10 33:25 36:1 39:23 55:12 71:7,21
approves 71:9
approximately 45:5
apps 33:9
ARDMS 61:15,16,24 63:20 64:4 74:9 76:12 76:14
are 4:16 6:16 7:10,10,19 8:8,25 9:9 10:7,19,22 11:7 12:22 13:24 14:5,9 14:14,20,21 15:6,13 16:10,25,25 17:10,14 18:23 24:10 33:13 34:11 35:7 39:7 41:5,13 41:15 43:8,17,25 44:16 45:1,22 47:22 48:8 49:12 53:13,19,21 54:5 54:18 55:17 57:10,11 57:12,14,15,21,24 58:2 58:7 59:3,15,17,20,23 60:23,25 61:13,15 63:12,25 64:8,9,12,16 65:13 66:16 69:11,24 71:17 73:16,19 75:1 76:1,2,6,13,13 77:4,24 78:1,10,10,11 81:8,8 85:19 86:19 89:2,5,9 90:2
area 15:24 16:2,14,16 27:8 44:24 85:6
areas 39:14 40:6,7 50:9 61:2 65:5 77:5
aren't 16:9 54:19 58:6
argument 69:17
Armstrong 11:18
around 10:19 16:1 44:8 57:2 59:13 79:13
ARRT 13:23 40:6 43:3 44:21,24 46:22 56:13 57:6,7,24 58:10 61:14 62:19 63:19 64:1 65:22 67:2,4,11 68:4 72:9 74:7,17,23 75:3 76:3,12 77:2,19 78:12 82:11,13 82:23 83:12,17,21 84:1 84:2,11,13,15
ARRT's 51:13 82:1,21
as 7:13 8:13,13,14 9:8,8,9 9:10 11:25 12:13 13:4,4 15:16,17 16:1 17:3,4 18:19 19:18,18 20:8,22 20:24 22:10,13,13 28:5 28:5,10,12,22,22 32:4 33:1 36:4,5,9 37:14 40:5,12 41:10,25 42:10 42:25 43:20 45:23 46:9 47:10,17,17,20 49:7 50:15 54:5,12 55:9,17 57:12,16 59:15 60:2 63:5,11,22 64:1 65:21 67:23 68:3 69:18,18,18 70:13,13,20,22,23,23 70:25 71:18 73:12 74:2 75:3 77:23 78:19 79:11 79:25 82:1,18 83:17 85:19 87:8,10 90:18,21 92:10
ask 40:20 47:24 73:18 86:17
asked 21:22 23:13,17 27:11 57:8 67:3 84:10 87:5 88:6,16
asking 64:23 87:23
ASRT 57:6 58:10 76:9
assigned 9:22
assigns 41:10
assistance 87:13
assistant 43:20 50:15 58:23
associate 43:16,18
associated 29:9,20 30:1 69:20
association 71:7
assume 74:22
assuming 7:7
Assurance 2:11
asterisk 44:10
at 3:24 6:24 8:5 12:20 14:14,21 15:5,12,14 16:7 19:16 20:12,12,24 21:9,23 23:13 25:6,10 28:7 29:7,16 33:9,10 34:18,19,24 36:22 37:7 37:24 38:5 39:16 41:23 43:8,11,19 44:13 45:20 46:7 47:8,23 49:8 50:5 51:21 52:5,15 56:13,19 57:7,13 59:8,11 60:22 62:19 64:14 65:16,20 65:21 68:21 69:5,11 72:4,6 73:3 74:2,2 75:20 78:2,23 80:9,11 80:12,18,21,21 89:8,18 90:16 91:3
Atherton 2:4 3:6,6 14:5 22:23 23:20 24:1,21 29:18,22 30:21 31:4 37:18 79:8 83:8,23 86:6
attempt 60:19
attorneys 52:5
authorized 92:8
automatic 15:16
automatically 34:1
available 5:17 27:13 32:14 57:16 65:23 66:14 85:9
average 79:2 85:7
aware 32:7 55:20
away 7:2 16:15 19:1 89:21,23
awful 87:21
axles 79:13
Aye 86:2,3,4,5,6,7,8
a.m 1:10 65:20

B

B 26:15
back 6:6,10,17,18,19 7:15 12:24 16:6 20:7,13,19 27:22,23 28:17 30:12 32:15 34:19,20 36:22 37:6 40:20 51:20 53:7 58:10 67:4 68:17 78:21 79:22 80:13 87:13 89:12 90:2,2,4
background 28:3,3
backgrounded 28:2
bank 15:11,15 78:3
banking 6:13
Baptist 3:24
barring 60:20
base 34:7 35:23
based 13:15 25:20 45:7 70:22 82:13,25
basic 14:7,10 43:12 64:1 68:23 72:15 75:16,25 77:3 80:23
basically 29:2 30:23 41:6 41:8,13 42:10 43:11 55:1 57:23 62:16 86:18
basics 14:12
basis 17:12
be 7:5,22,22 8:12,15,18 8:20 9:2 10:21 11:12 12:15 14:3 15:5,16 17:12,13,24 19:12 20:24 23:19 24:18 25:1 25:6,9 28:3 29:10,24,24 30:3,4,6,8,25 32:6,6 33:22 34:1 35:14,19 37:6 38:7,14 40:20 41:22 42:12,22 44:11 46:2,5 47:4,13,14,16 48:3,14 49:5 50:21 52:12 53:12 54:21 55:7 55:12 56:1 61:2 62:3,13 63:2,14 64:5,8,19,21,23 67:2,23 69:2,6 71:16 72:11 73:12,15 74:2 75:8,9,12,15,15 77:15 78:8 79:10 81:5,9,16 83:23 84:7,7,21 85:18 86:23 87:21,25 89:3,19 89:20,25 90:22
Beach 4:6
beaten 51:9
beautiful 60:17
beauty 84:20
became 21:20 51:15
because 7:1,2 9:9 14:18 14:24 15:22 16:12,18 21:3 22:20 27:8,13,24 29:22,24 31:2,6 32:14 32:17 33:9 37:4,10,15 37:17 40:16 47:25 48:7 48:15 49:15 50:8 52:2 55:12 61:24 62:14 63:5 63:10,12,15,25 64:8 66:1 68:20 71:20 74:21 77:19 78:16 79:18,23 80:12 82:19 83:10,11 84:21,25,25 86:16 89:18
Becker 2:9 3:21,21 6:22 6:23 8:1,4,7 9:13,15 10:6 11:17 12:8,18,24 13:3,6 18:22 19:8,11 21:14,16 22:24 23:11 23:19 24:5 25:13,16 26:10 29:21 30:3,17 31:7,18,22 32:12 35:16 38:20 39:6
become 23:14 81:15
becomes 21:25
becoming 7:17
been 9:3,17 14:25 17:20 25:12,13 32:2,17 34:16 34:17 77:18
before 5:20 12:16 14:2,18 17:17 19:1,2 27:5 31:8 34:13 37:5,16 55:22 56:2,4,14 59:4 61:11,18
beginning 20:15 82:2
begun 11:19
being 7:19 15:2,4 21:7,21 21:23 23:22 24:22 28:11 48:20 72:14 88:1
believe 12:25 16:16 21:18 28:10 50:17
below 57:23 58:5 85:5
beneficial 87:25
benefit 10:22 11:11
Berryhill 1:23
besides 25:25 29:17
best 17:5 55:25 84:7
beta 40:25
better 8:20 45:11 79:17 89:20
between 20:1 23:7,9 26:19,23 27:20 58:11 58:12 59:8 89:14
beyond 39:14 43:12 49:3 66:15
big 9:8 40:15 45:7,9 62:23 66:4
biggest 60:18 65:23 66:16
bill 3:6 30:10 39:19,19,20 40:2,14 41:7 45:4 50:10
Bill's 12:2
binder 27:17
binders 7:1 35:6
birds 27:14
bit 8:11,13 9:7 14:11 20:18 28:12 33:17 39:11
bits 9:7
Blackmore 12:19 13:1
blame 18:7
BMO 75:15
board 4:10 5:13 48:15,19 55:12,14 56:3,4,6 81:3
boards 53:23
body 28:7,9,16 37:21
bolts 82:20
Bonanno 2:4 3:10,10 4:20 7:25 8:3 9:12,14 18:14,16 21:15 23:4,8 24:3,9,17 25:9,15 26:7 30:15,19 31:5,8,16 32:11 33:1,5,16,24 34:6 35:3,5,17,21,25 36:11 37:8 38:2,19,21,24 39:2 40:17 43:22 47:14 48:1 48:6 49:8,12,21 50:1,12 50:19,23,25 51:12,22 51:24 52:10,12,18,24 53:7,12,19,22,25 54:16 54:23 55:9,13 56:8,10 60:15,17 61:16 66:12 74:13,21 75:22 85:24 86:3,15,25 87:20 88:1,5 88:13,16,23 89:2,8,23 90:2,13,19
bone 54:17 58:21 67:10
bonuses 39:3
book 43:10
border 20:1 21:9
borders 25:11
boring 19:12
both 16:5 17:22 45:24 46:21 74:8,21 83:14
bottom 31:21 44:13
bought 86:22
Boulevard 1:24
Braco 19:17 21:11,11,14 21:15,16 24:16 27:5 29:5 33:21 35:8,9 38:22 38:25
Braco's 32:24
brand 50:1
break 13:4 36:4,5 39:8 56:12,14 65:18
breakdown 45:14
breaking 21:6

breaks 63:24
breakthrough 32:16,20 33:22 34:15,16 35:12 35:14 36:23
break-through 20:10,23 22:3
breast 58:17,20 63:8
breathe 8:7
Brenda 2:10 4:2 5:22 6:25 8:25 18:1 89:11
brief 39:9
brightest 17:5
bring 26:16 47:7 52:17 86:14
bringing 22:19 71:2 79:18
broke 41:9
broken 8:10
brought 47:4 86:15
budget 11:14 16:12
build 63:1
building 16:17
built 23:9 31:4 33:25 52:7
built-in 63:7
bullet 32:14,21
bumped 13:25
burdensome 63:25
bureau 1:2 2:8 3:25 4:2 7:10,13,17,23 8:12,14 9:8,10 10:17 11:2,8,24 12:7,18,25 13:6,7 18:23 19:18
bureaus 8:8,11 9:10 10:17
Burress 2:5 3:8,8 12:17 35:12,19,23 36:14 86:4
business 2:10 4:13 86:12
busy 5:1,2
but 3:4 6:16 7:3,7,9 8:13 8:20 10:19 11:7,24 12:13 13:10,24 15:6,14 16:7,8,10,11,25 17:12 17:21 18:11 19:4,24 21:5,16 22:5,24 23:2 24:1 25:17 27:4,14 28:22 29:2,10 30:7,20 30:25 31:17 32:12,21 32:24 33:8 34:23,23 36:5,6,19,25 37:1,3 38:10,13 40:14 44:9,12 44:25 45:9 47:20,21 48:10,17 49:20 51:9 53:4,19,20 54:14,24 56:22 57:24 59:24 60:3 60:10 61:21,24 63:7 64:7,20 66:3,19 67:11 67:14 68:2,10,24 69:3 69:11 70:1,13 71:17 72:7,18,24 73:24 74:15 75:24 77:18 78:1 79:20 80:1,18 81:23 82:16,21 83:2,6 86:15,19 87:12 87:20 88:3,4,25 89:3,17
buy 29:25
by 1:18 4:14 8:25 10:13 14:4 16:19 21:11 25:5 26:14 27:24 30:10 33:9 35:25 38:16 40:7,11 41:18 42:21 43:5 45:16 46:9 48:10 55:12 57:24 58:7,18 59:1 61:8,14,20 65:6,11 71:7 72:14 73:5 73:5 81:17,17 83:10 90:3

C

C 2:1 76:1 92:1,1
calculated 36:21
calculations 25:5,7
calendars 89:12
calibrated 34:11
calibration 20:9 26:20
calibrator 23:8,9 34:8,9
calibrators 26:8
call 10:8 34:14,19 35:9,10 39:6 76:21 77:20
called 7:10 34:20 40:4 58:8,19
came 21:21 27:4 28:17 48:15 50:12 57:6,20 59:20 62:12 68:5 74:20
cameras 30:22
campuses 15:22,25
can 6:3,5,17 7:13 11:12 12:11,19,20 17:8,15,22 19:11,24 20:18 29:16 35:14 36:4,5 40:19 41:24 42:10,15,17,21 44:12,17 45:13 46:6,24 47:14,17,20,21 48:1 51:4 52:14,18 54:16 56:24 58:12 59:12,15 60:2 62:16,24 63:3 64:3 64:5,13,23 65:8 67:15 68:1 69:5,12,12,21,24 70:13,22,24 71:1,11 72:1,10,21 73:1,7 74:16 74:18 76:5,5 81:11,13 82:22 85:5,5 87:20 89:10,21
Canada 20:2
candidate 82:19
cannot 51:4
can't 7:2 9:5 18:8 19:1 66:18 69:12,13 73:8
capability 13:24
caption 92:10
card 15:3 58:1 72:20 73:3 73:4 75:3
cardiac 30:23 31:1 38:6 58:2 64:12,16 76:15
cardio 57:22
cardiology 31:1,19 43:13 43:25 44:4 48:25 49:3 49:15,22 56:18
cardiovascular 58:8 76:4
cards 75:7
care 16:4 17:19,25 66:11 84:4
careful 24:18 54:21 77:11
Carol 2:4 3:10 21:13 23:2 24:15 32:4,23
carotids 64:13
Carrabba's 17:21,24
carry 37:9
case 31:7 47:2
categories 43:4
category 43:6 58:16,22 60:9
caught 37:6
cause 92:10
CCSP 2:4
CDC 19:19 23:13 26:25
center 4:5 86:22
centers 31:13
certain 77:4 78:10
certainly 81:13
certificate 59:14 60:24 72:19 82:13 87:8
certificates 44:18 58:25 59:15,16,18,19
certification 4:8,10 5:19 43:1 44:22 45:6 61:7 62:1,17 64:24 68:5,6,9 69:2,5,7 71:14 83:3
certifications 62:25 63:23 64:5 69:14
certified 43:12 48:10 49:16 61:14 74:3 88:9 88:12 89:1,3
certifies 71:8
certify 40:7 69:9,11 92:8
cetera 16:12
Chair 3:13
change 7:22 40:11 42:4 46:14 53:16 77:7 79:6 84:11
changed 12:13 33:17 40:20 75:21 78:20,22 84:21
changes 12:14 42:1
changing 77:20 79:16
Chapel 92:15
Chapter 39:25 90:11
charge 70:2
chart 7:4,4
charts 20:12
check 58:19 70:11 75:7
checkbox 70:11
checked 21:18 34:8 36:6
checkpoint 37:7
checks 18:4,5
Chief 11:24
Chiefs 12:7
Chiropractor 3:7
choose 7:24
CHP 2:5
CI 58:1,5,6 76:6
Cindy 2:9 3:21 6:22 39:5
Cindy's 12:3 56:9
Circuit 92:6,6
circulation 78:2
circumstances 55:25
Citrus 16:14
city 34:24 92:15
claimed 29:5
classes 14:25 16:24
clear 15:13 54:6
clearance 37:7
clearly 85:10
clients 31:24
clinical 5:11 72:25 73:4 74:4 75:24
close 69:18 72:14
closely 56:17
closer 89:18
closing 8:24
CMS 60:23
CNMT 2:4,7
colleagues 46:13
collecting 26:21 29:15
college 17:10 75:5
column 41:7
columns 41:10
come 5:15,15 22:20 29:4 37:23 40:12 45:10 46:3 50:2 56:23 69:19 79:22 82:18 83:10,24 84:3 89:13
comes 14:19 57:19 66:5
coming 5:1 17:1 47:2,9 57:2 65:16 68:16 82:3 82:11 83:10 90:4
commenced 3:1
comment 42:16 61:12
comments 4:16 17:7
committee 80:7
common 37:4 88:15
community 7:20 8:9 12:12,13 30:11 51:1 61:23 62:12 63:2
competent 60:25 81:9
complaints 63:17
completion 17:11
component 69:22
computer 33:10,25 34:2
computer's 43:7
concern 37:21
concise 44:5
concluded 91:3
condition 32:1
conditions 28:23
conference 19:16
confused 23:20
consider 30:7
considered 28:3
considering 28:20 30:4 49:21
consistent 41:22 46:5
constitute 92:11
Consultant 2:10,13
contact 27:11
contacted 27:11
contaminate 36:16
content 44:13 45:14 77:1
continued 65:21
continuing 64:25
contract 15:15 83:21
contrary 60:21
control 1:2 2:8 3:22 4:1,3 4:4 5:3 7:10,23 10:9 11:5 13:10 18:24 19:18
Cooksey 2:10 4:4,4 5:22 11:16 12:1
coordination 51:18
copyrighted 46:11
corner 72:21
corporate 33:23
correct 48:14 55:3,6 68:13 72:18 77:21 78:18 80:25 81:19 82:24 92:11
corrections 4:17
correctly 25:8 26:8 79:3
correlation 26:19 35:1
cost 38:22,25 69:20
could 15:14 17:18 21:13 21:19 25:9 26:23 27:9 27:11 30:25 32:23 45:10 47:16 49:7 51:3 52:4 54:13 56:1 62:17 62:18 63:16 68:6,9 69:2 86:21
couldn't 23:23 30:17 44:5 68:3 76:6 90:22
council 1:3 2:3 39:15 47:5 79:24 86:13 89:18
count 60:9
counted 27:17
counter 34:7
counterparts 42:1
counters 34:4
counting 28:7
country 30:15 38:14 49:19 53:13 59:1 84:9
counts 28:4,5
county 3:17 10:10,13,25 16:14 92:3,7,15
couple 20:3 30:18 39:12 44:3 45:1 52:4,21 70:17 87:4,23,24
course 27:12,24 28:17,25 57:2 58:21 70:1 89:15
Court 1:19,23 92:5,6,24
covered 58:7,18 61:8 65:6
created 48:16
creating 48:12
credential 57:11,20,25 74:25
credentialing 75:1
credentials 76:3
credit 15:2 75:4
cribbed 44:7
cripple 49:17
criteria 83:17

crunches 16:12
CT 38:17 43:1 44:25 47:21 49:23 51:24,25 53:22,23 54:4 58:21 59:12,23,24 60:13,23 61:4 65:8,24 66:6,9,10 66:10 67:23,23 68:2,3,6 68:7 69:13 70:14 74:8 76:16
curiosity 9:12
curious 30:21
current 7:4,5 40:24 47:15 58:13,25 67:25 70:7 78:21 85:14
currently 14:14 43:1 44:16,19 57:13 59:9,10 65:5,6,11 74:16 79:4,15 85:19
Curry 2:13 4:7,7 13:14 14:7,15,17 15:10 24:23 25:22 70:4 71:24 72:1,4 75:8 82:9,17,24 83:9,15 83:20
customs 20:1,4 21:9 37:7
cut 77:21
cutoff 25:10
CV 57:22,23 58:5,6
cycle 9:21
C1 39:24
C11 76:11
C2 41:3
C3 42:24 44:14
C4 57:5
C5 58:24
C6 72:13
C8 76:4

D

D 76:18,23,25
DACBR 2:4
Dade 71:24
daily 33:18
dangerous 38:11
Danny 88:16
data 29:15,16 33:6
database 42:2 46:14
date 6:8 7:6 22:20 26:20 27:20 46:9 89:14
day 9:6 15:14 24:12 25:3 33:3,5,9 34:8 35:1,8 36:6 92:16
days 14:14,15,22 15:13 22:17,24 27:18
Daytona 4:6
day's 33:11
DC 2:4
dead 30:23
deal 15:4 43:1 54:7
dealt 87:13
decayed 36:20,21
decide 17:18 18:1 41:16 63:19 65:18 71:11,19
decided 18:13 63:18 66:6 84:12
deciding 9:16
defer 82:19
deferring 51:10
define 51:18 56:24 61:18 71:3
defining 47:9
definition 40:11,21,24 52:15 56:19 62:4,5,10
degree 43:23,24
delineation 51:14
DeLOATCH 3:20,20 5:4,6 5:9,11 45:18 47:4 48:5 48:14 49:17,20 50:17 52:15 55:18 56:2,5,9,16 57:4 88:18 90:11
demographics 14:20
demonstrate 60:24
Dempster 1:23
densitometry 58:22 67:10
department 1:1 3:13,14 4:1 6:21 7:12 9:16 10:10,14 39:13 42:3 71:8,11,18
departmentally 11:23
departments 10:11,25
depending 78:25
depends 15:21
deposited 14:20
Deputy 12:5
description 44:6
design 77:13
detected 21:8
detection 20:2,5 21:8
detector 37:14
determine 27:1
develop 68:25 72:10
developed 51:3 55:17 70:19
development 42:11 71:1
device 22:9
devices 21:8,17,19,24 40:12
diagnostic 68:3,6 76:15
did 7:23 9:12,13 12:17 13:6,10 18:11 21:24 22:4,7,9,21 25:6 26:11 26:22 27:5,14 28:1,12 28:15,15,21 29:21 31:6 31:10 34:21,22 45:3 50:3,10 55:9 56:12 58:19 61:20 65:18 79:22 81:5 84:12 92:9
didn't 20:14 24:3,25,25 26:7 29:8 31:5 37:2 61:18 68:14 71:22 79:6
difference 26:22,23 48:3 57:18 67:6
different 9:23 10:23 15:22 17:13 34:13,23 41:11 44:7 46:17 49:23 49:24 59:5,18 62:5,24 64:4 65:10 67:10 71:17 72:25 74:10 80:10 85:1 85:4
differently 84:19
difficult 78:8,16
difficulty 54:4 78:12
digital-focused 77:9
digress 77:25
diluted 23:5
direct 51:6
Directives 41:7
directly 10:23 23:4,5 47:16 61:20
Director 2:12 3:16 4:9 11:24 12:9,10
directors 5:13 12:6 15:23 18:25
disciplines 81:6
discovered 20:5,20 32:17
discuss 42:1,3,7 85:16 89:10
discussed 65:22
discussion 5:16 60:20 65:24 76:17,18
discussions 51:16
distilled 24:19
distinction 74:16 83:5
distinguish 58:11,12
distributed 4:14
divine 76:6
division 7:11,14,17,19,20 8:8,11,14 10:7,11,16 11:24 12:6,9,9,10,11
do 5:3,20 6:5,9,10,12,18 8:21 12:20 13:23 15:1,3 16:5 17:17,23 18:3 19:8 21:22 23:6,14,18 24:23 24:25,25 26:6 27:16 28:11 33:8 34:4 38:13 39:21,23 40:6,18 41:14 46:6,21,24 47:19 48:25 49:13,20 50:17,19 51:4 52:1,1,4,14,22 53:4,6 54:14,16 57:9,13 59:9 59:18 60:25 61:9 62:9 62:17 63:3,12 64:10 65:1,8,12 66:3,5,6,8,15 66:18,19 67:15 68:1,3,6 68:8,17 70:22 71:3,17 71:23 79:4,14,16,22 80:10 82:9,16,17 83:6,8 84:12,14,15,24 85:5,5 85:21 86:21 87:14,21 88:25 89:7,8,17 90:2 92:8
document 58:12,13 75:9 75:11
documentation 75:2
documented 32:9
documents 29:4,10
DOE 17:9
does 9:11 11:1,3,14 17:25 22:17 32:5 34:11 36:3 50:8 58:11,20 61:5 63:6 63:6,7 81:7 82:6 83:6 85:8
doesn't 18:11 32:21 54:25 62:6 74:19 81:6 84:21 87:14
doing 8:6,13 10:23 14:24 17:14 24:11 29:11 30:22 31:1,12 33:7 55:23 60:23 64:9,10,12 64:13,17,19 67:23 70:23 77:19 80:16 86:20
dollars 38:23 39:1,2
done 15:14 20:21 25:5,6 25:24 26:11 27:9,18 34:1 36:18 37:4 38:6 39:5 41:25 45:10 47:16 48:10,20 49:1 55:23 62:23 81:5
don't 3:4,5 7:5 8:7,21 9:19 11:9 13:4,22 18:1 18:6,8 25:16 29:6,7,25 32:20 33:12 34:10 36:25 37:22 38:12 44:11 47:19,23 48:8 49:4,6,10 51:21 52:2,22 53:15,16 55:21 56:13 57:13 61:22,24 63:10 64:18,22,23 65:17 66:2 66:3,5 69:3,8,18 72:15 73:14,14,19 74:8,8,15 74:16,23 75:22 80:1 82:14 84:5 85:8 86:19 88:2,4,11,13
dose 23:8,9 25:4 26:8 28:6,8 34:8,9 35:13 38:7,8,15
doses 24:7 34:5
down 5:15 8:10,24 9:19 11:22 12:8 13:4 15:24 18:19 27:13 31:2 33:14 34:21 48:8 49:13 50:2 57:23 58:2,4 62:11 63:24 70:20,25
downturn 17:2
Dr 2:4,6 3:2,6,23 4:12,16 4:21,23 6:21 11:1,14,18 12:15 13:5,12 14:5 15:18 16:21 17:7,15 19:6 22:23 23:20 24:1 24:21 25:4 29:18,22 30:21,22 31:4,14 32:23 36:9,12 37:11,18 38:5 38:17,22,25 39:7 40:21 48:3,12 49:7,10,14,18 50:21 54:9,12 55:7,11 55:25 56:4,6 60:3 61:5 61:7,12 64:6 65:1 66:6 66:9 68:8,11 71:3,11,20 76:24 79:8 81:11,14,23 82:3 83:8,16,23 84:14 85:8,13,16,21 86:1,6,9 86:12,23 87:17 88:3,25 89:9,21,25 90:4,24 91:2
draft 40:9
drafts 55:17
drawing 24:7
driving 18:19
Drotar 2:5 3:13,13 10:4 12:2 14:23 15:21 16:23 17:8 18:3 51:17 60:8,22 61:4,6,8 63:24 66:23 67:7,12,14,18,21 68:20 69:10,16 73:21 74:25 80:3 84:24 85:15,25 86:5 90:15 91:1
dual 88:25
dumber 80:16
duplication 60:7
during 19:19 22:14,15 35:1

E

E 1:24 2:1,1 92:1,1
each 3:4 44:16 59:12 60:9 60:13 76:3 84:25
earlier 26:17 32:5
early 78:21 90:8
earned 78:17
earns 79:21
easiest 52:25
easily 36:5,5
easy 79:12
eat 17:21
economics 73:15
educational 69:1 71:9
educators 80:10
effect 37:25 39:20
effective 11:18
effects 37:20
efficient 14:16
eight 24:12
either 8:21 63:13 81:16 88:13
electronic 13:22 14:3
electrons 40:25
eligible 43:17 75:19
eliminate 47:15 49:14
else 5:20 10:1,1 11:10 27:5 40:14 56:15 63:17 85:16
embarrass 37:2
embarrassed 24:25
emergencies 11:2
emergency 7:20 8:9 10:16 11:1,5,8 12:10,12
emission 43:14 44:1 45:12
EMT 4:7 5:13
EMTs 4:10
encompassed 16:13
encourage 48:25
end 11:25 12:17 53:2
ended 12:18 27:15,24 59:21
endorse 85:13

endorsement 40:7 43:5 70:4,7 74:17,18 81:18 81:19 83:11
endorsements 70:24
enough 5:14 17:20 49:20 54:24 55:2
ensure 81:7
entire 8:14 38:14
entry 49:4 80:23
envelopes 6:11
environmental 7:11,14 7:17,18 13:5,7,8
envisioned 50:10
epidemiological 23:14
Epidemiology 12:25 13:8
equals 60:4
equipment 20:3 27:16 28:4
equivalent 81:21
errors 34:2
especially 13:25 82:9
essentially 40:14 72:24 87:6,15
established 35:25
estate 72:22
estimated 45:3,4
et 16:12
evaluation 77:6
even 15:5 22:5 25:12 32:21 34:20 36:24,24 37:24 47:23 60:6 62:14 73:8 78:15 79:15 81:3 84:21
event 19:23 37:24
eventually 29:24
ever 33:25 49:4 75:22 83:12,23 84:14
every 9:6 24:13 25:3 29:10 33:2,2,5,9 34:8 36:6 42:18,18,19 76:25 80:18
everybody 6:23 11:20 15:3 19:5 23:11 32:22 86:16 88:20
everybody's 55:20
everyone 3:2 4:12 5:1 6:1 8:16 12:15 30:9 35:5 53:9 91:2
everyone's 12:4
everything 15:17 40:3,14 46:21 59:7,9 74:1,24 86:10
evidence 92:9,13
exact 44:9
exactly 37:3 39:21 60:16
exam 44:13 45:14 47:18 47:20,21 48:1,16 49:4 67:1,2,13 68:12,18 77:22,23 78:2,7,8,13,16 79:1 81:8,12,17,17,22 81:23 82:1,1,6,12,17,18 83:13,16 84:15 85:5 87:18,20
examination 77:2
examines 71:8
example 10:17 42:25 55:9 72:13
examples 54:5
exams 60:25 77:3,3,14 80:15
exceed 73:13
except 42:19 46:21 60:11 70:16 77:3 87:10
exception 51:10,16
excerpt 55:7
excerpted 44:2
Executive 2:12 4:9
existing 62:6 71:6
expect 73:11,25
expected 54:6
experience 49:3
expert 53:13
expertise 11:5 53:4
explain 77:16
explains 80:4
extender 43:21,22 50:9 50:22 51:19
extra 49:2,2
e-mail 4:14 33:8 76:21

F

F 92:1
FACC 2:6
facilities 16:3 20:19 21:23 21:24 26:21 27:3,7,10 27:10 31:10,18 76:20 87:4
facility 29:10 87:23
fact 65:13
facts 61:10
FAHA 2:6
fairly 46:1
fall 40:9 61:5
far 7:2 8:13 9:8 11:16,17 19:1 47:17 70:23
favor 86:1
FDA 19:18 21:10 23:13 27:24 28:25 36:1
FDA's 33:1
February 22:15 27:20,23
federal 66:17
fee 70:8
feedback 42:14
feel 6:17 46:18
feeling 12:4
feels 17:23
Fester 39:5
few 19:23 36:22 61:10 62:21 71:21 83:9,9 84:10
fewer 59:25 78:15
field 8:16,22
fields 69:24,25
figure 23:16 25:22,23
figures 37:19
fill 6:3,5,13,17 33:16
filling 16:11
film-focused 77:9
finalized 55:22
find 15:7 21:19,23 26:11 26:23 28:1 44:5,9 76:7
finds 79:21
fine 29:20 30:1,9 31:4 35:10
fines 29:18,21
finished 42:21 52:23
first 4:13 7:3,9 8:6 9:13 9:15 25:16 27:4,21 36:1 41:14,24 43:8,10,17 44:3 45:6 51:15 60:19 65:25 66:7 71:15 77:16 79:20 84:1 87:15 89:21 90:9
fiscal 13:15
fit 55:2
five 8:11 28:1 39:16 50:13 80:19 85:4,7
flavors 63:23
flexibility 54:25
flight 37:10
flip 44:15 58:24 73:22 76:5,8
Florida 1:15,25 3:7,8,11 3:18 4:1 5:3,10,17 14:6 19:24 20:8,20 21:22,25 22:14 25:24 27:1 30:20 31:16 38:1 41:17,19 42:23 44:17,19 45:8,15 46:2,12,13 47:7 49:17 49:18 50:24 51:14 57:14 59:9,10,14 61:23 62:25 65:9 67:15 68:1,5 68:17,18 73:20 78:23 84:4 88:9,12 89:8 92:2 92:7,15
Florida's 59:1 68:19
FMT 33:10
focused 10:22 89:16
fold 6:10 71:2
folks 8:19 10:14,22 11:7 12:17 20:3 40:6 44:16 46:17 57:24 60:21 61:25 62:23 66:11 67:8 77:18 84:22 88:9
follow 28:25 29:2,8 32:8
followed 46:19
following 3:1 46:18 90:5
follows 65:21
followup 37:19
for 3:17 4:10,25 5:11,13 6:1,8,11,25 8:20 9:2,4,8 10:16 11:5 12:4 13:22 13:25 15:4,8,19 17:4 18:9,12,24 19:5,14 21:4 21:4 24:6 25:13,24,24 28:4,7,15,16,18,19,23 30:17,23 32:1,14,22 34:22 36:2 37:21 40:20 41:4,11,12,19,20 42:9 42:16,19 43:3 44:13 45:4,17,21,23 46:6,21 46:23,24 47:10,11,17 47:22 48:9 50:8 51:9,11 51:14,19 52:1 56:12,14 56:22 57:1 59:6 60:12 62:25 63:14 64:4 65:5 65:20 66:4,10 67:2 68:2 68:13,18,22,23 69:2,4,6 69:10,12,13,19,23 70:16,24 72:6,9,22,25 72:25 74:1,8,17 75:2,2 75:19 76:3,14,15 77:1,3 77:25 79:23 81:11,19 82:10,14,15,20 83:13 83:14,18,22 84:14,18 84:18 85:9,10,22 86:10 87:4 88:2,21 89:13,20 92:5,7
force 18:19 48:24 62:2
foregoing 92:11
forget 10:18 72:1
form 33:16,17 67:19 78:7 78:8 79:1,2
forms 33:18 78:2,11,13
forth 10:15 46:14 72:9 73:11 77:6
fortunate 39:18
forward 20:16
found 26:17 27:22 28:9 28:10,12 36:17 46:7 48:17,19 81:1
four 8:23 16:24 17:3 27:18 39:16 50:13
fourth 32:13
fraction 77:17
fragment 36:24
frame 27:21
frames 26:20
free 6:18
free-standing 16:3
Fridays 17:21,24 65:19
from 9:3 10:12,20 11:19 11:21 13:15 14:17 18:23 19:12,18 20:7,8,8 21:8 22:21 26:21 27:4 29:4,15 30:11 33:21 34:14 35:7 36:19 41:9 42:9,14,22 44:2,7 45:12 46:20 47:2,6,14 51:25 53:1,7 55:4 56:23,24 57:6 60:21,22 61:21,24 62:8,19 64:25 67:4,11 70:14 74:10,18,25 78:20 81:23 83:10
front 16:6 53:9 87:2
full 67:13,13
fun 57:3
funds 15:16
funny 82:10
further 58:2 76:17
fusion 34:6,10
Futch 2:9 3:25,25 4:25 5:7,10,14,25 6:13 8:2,5 10:7 11:4,23 12:3,22 13:2 17:17 18:5,10,18 19:5,10 21:13 23:1,6,13 23:23 24:15 25:18,23 29:17 30:10,16 31:20 33:13,20 34:25 35:4 37:22 38:12 39:5,10 40:18,23 43:24 45:19 47:12 49:25 50:4,16,24 51:1,5,8,13,20,23,25 52:11,21,25 53:8 54:3 54:14,18 55:1,4,16,19 56:12 57:1,5 60:6,10,16 60:18 61:3,10,15,17 63:18,22 65:3,22 66:8 66:10,13 67:3,8,16,19 67:25 68:9,14 69:15,17 70:2,7,16 71:5,12,23,25 72:2,5 73:11,17,22 74:15,22 75:6,11,16,19 75:24 76:25 79:9 81:10 81:13,15,25 82:5,7,16 82:18,25 83:4,14,19,21 83:25 84:17 85:12,18 86:10 87:2,19,22 88:7 88:14,20 89:11,15 90:7 90:14,17,20
future 11:24 30:6 40:13 40:19 61:19 62:11 85:19
F18 26:1

G

G 8:22
Gail 2:13 4:7 41:25 57:19 75:6
gallbladders 64:14
gamma 25:20,21 40:24
gave 68:5
general 11:18 12:5 14:8,9 64:17 72:16 87:9
generator 20:22 23:5 24:10,13,20 29:6,25 31:25 32:2,10 34:23 36:2,9 38:14
generators 20:22 21:11 22:13,16 26:18 27:25 29:14,15 30:12 32:13
get 3:2 5:20 6:19 8:2 9:19 12:3,14 21:1 23:23 24:11,13,13 25:19 27:9 27:15 30:12 33:18 36:12 37:6 42:14 44:11 46:11 47:1 50:6 53:18 53:23 54:22 59:25 62:22 69:6,12,12,13 77:21,22 78:25 79:3,12 79:14,16 84:14,15,18 84:24 88:14 90:2
gets 7:7 14:20 33:25 36:10 55:22 63:25 85:2
getting 13:25 14:1 51:8

51:20 55:4 67:10 68:16 80:25
give 6:17 13:14 20:18 46:10 66:20 73:23 74:17,18 75:3 82:12
given 33:22 36:7 78:2
gives 71:18
giving 66:18 67:8
Glad 3:3
glucose 24:19
go 5:22,25 6:5 11:3 13:10 15:7 16:5 17:25 18:21 20:11,13,14,15 22:21 23:18 26:16 29:1 37:6 40:20 43:10 44:8,24 45:9 46:13,15 52:11,22 53:18,23 56:2 63:3,16 64:4 65:8 66:2 70:20,25 72:8 74:12 78:3 82:22 84:2 87:5
God 56:10 71:25
goes 16:23 24:9 77:13 78:4
going 5:15,16,21 6:9 7:25 8:14 10:3,4 11:21 13:20 17:9,10,18 18:7 19:20 20:3,14 21:20 26:1,3,4 26:16 27:2 30:5,9 32:16 37:17,17 43:7 44:11 45:22 47:4,7,24 48:8,11 49:13 50:2,14,21 52:3 52:16 53:2,5,16 56:2,20 57:19,20 59:11 62:9 63:12,13,13,14 64:24 64:24 67:1,23 68:15 69:6,11 70:1,10 71:16 71:17 72:8 73:15,16 74:1 78:5 79:23 81:15 81:16,19 82:21,23 84:6 84:20
gold 34:9
gone 21:3 80:4
good 3:2 4:12 9:9 14:11 16:21 19:3 21:2,4 30:4 30:4 32:13 53:9 65:17 76:21,21 90:7,18
got 9:22 15:3 21:10 26:9 27:5 32:11 34:14,22 36:9 37:10 46:1,11,20 54:21 58:9,13 60:8 63:8 64:10 66:22 67:4,11,23 68:4 72:22 73:18,21 74:10,21 78:13,18 83:14 84:25 87:2
gotten 38:3 49:2 64:2 80:13,16
government 57:7 65:11
Governor 12:16
grabbed 27:7
graded 77:4
graduate 14:25 15:6 36:14 80:23
graduates 15:20 16:8
granting 75:21
gravitational 18:19
great 18:18 35:11
gross 25:20
group 9:22 17:22 37:12 37:13 55:19 71:9
growing 16:17
guess 6:21 9:15 10:8,21 14:13 17:15 19:22,24 20:25 23:13 41:14 43:15 50:1 54:8 55:11 55:24 60:4 62:21 73:14 74:11 77:13 84:11 86:16 87:17 88:20 90:24
guessing 26:8
guesstimate 45:9 60:11
guesstimates 45:8
guest 3:20 5:3
guidelines 17:9 56:21,22
guy 63:5
guys 15:8 37:13 53:4 82:19

H

had 6:4 7:6 14:10,11 15:23 19:3,16,17,21,23 20:13,15 22:11 26:9 27:15,24 28:5,10 29:5,5 31:2,6,25 32:8,9,16,18 34:15,17,24 36:14,17 37:13,13 38:3 39:9 49:1 51:15 57:7,8 71:20 72:18 80:16 84:8 86:16
hair 38:18
half 15:14 38:7
half-life 21:2 22:23 37:10
Halifax 4:5
hand 92:14
handful 88:18
handle 11:2,9
handled 84:19
handout 26:14
hands 17:23
hang 57:2
happen 7:16 8:20 13:11 28:21 32:22 47:12 48:11 52:3 54:7 55:22 64:25 69:15 75:23 84:6
happened 20:1,19 23:15 23:17 25:11 30:6 31:9 37:3
happening 21:5 47:7
happens 11:10 34:2
happy 33:7 39:12 48:19 60:12
hard 30:8
hardly 83:12
harmful 37:20
has 10:8 13:23 14:2,25 17:20 20:2 21:1 26:5 32:2,6 33:14 35:6 39:16 40:3 43:9 49:18 53:15 55:12,13,14 59:13 63:5 66:16 68:22 73:5 74:7,7 75:20 81:20 85:1 90:10
hasn't 78:20,22
hate 21:16 52:6,7
have 5:3,16,17,20 6:1,2 6:11 7:5,6,19 8:18,21 8:23,24 9:3,6,11 11:4 11:17,19 12:8,11,14,16 13:18,18,22 14:13 15:14,17,18,22,24,25 16:4,8,14,19,21,24 17:3 17:4,9,10,18,18 19:8 20:22 21:24 22:16,19 23:6 24:12,18 25:12 27:11 29:1,13,14 31:6 31:10,14,14,20,24 32:17,19,20 33:8 34:2 34:17 35:5,10 36:2,10 37:5,8 38:3,8,21 39:18 40:10,18 41:14,17 43:11 44:23 45:10,19 45:21,25 46:5,15 47:19 50:2,14,17,19 53:4,13 54:18 56:8,15,19 57:9 57:24 58:22 59:9,10,24 60:6,13,15 61:18,22 62:1,7,15,16 63:6,6,7 63:14,15,19,22 65:8 66:6,8 68:12 70:10,18 71:13,14 72:8 73:19 74:8 75:10 76:19 77:4 77:18,24 78:7,15 79:2,8 79:13,16 80:3 81:12,20 82:14,16,17 83:2,9,11 83:11,12,21 85:9,21 86:13 87:14 88:3,23,25 89:12,17,18 90:20 92:14
haven't 17:1 23:1 82:20
having 7:22 10:22 15:1 25:24 30:14 32:19 42:20 53:3
he 16:23 20:14 37:15 72:2 86:20
head 3:23 61:11 63:5
header 59:6
health 1:1 4:1 7:11,12,14 7:17,18 9:16 10:10,13 10:18,19,25 13:7 18:24
hear 9:7 53:7 86:16 87:1
heard 8:18 9:6 11:21 16:19 19:22,23 25:4
hearing 51:21
heart 79:13
held 42:12
help 27:1 81:7
helped 16:3
helping 5:2
helps 7:1
hematology 73:7
her 33:9,10 36:16 37:2 56:11
here 3:3 6:7 7:21 9:18 12:19,20 18:12 19:4,5,7 20:25 24:1 27:2,13 29:1 37:3 41:13,24 44:3,11 45:13,20 51:9 55:8 59:21 62:19 66:11 72:17,19 73:13 90:22
HEREBY 92:8
hereto 92:10
hereunto 92:14
here's 45:20 60:11,12
Hers 78:8
hey 26:25 62:12
he's 10:3
Hi 3:6
high 20:24 26:9 28:5,10 35:9 40:25 86:19
higher 28:12 34:15,17,20
highest 64:19
highlighted 7:21 44:17 59:1
HIPAA 37:2
hiring 80:11
his 19:2 46:13
history 20:18
hit 14:18 53:2
hold 37:22 59:15
holders 59:14
holding 59:17 87:8
Holley 8:22
home 6:19
Homeland 25:5
homes 9:3
hooked 23:2
hope 8:17 32:21
hopefully 8:15 12:15 14:3 39:25 72:11 79:23
hoping 80:2
hospital 3:24 8:22,24 36:3 89:8
hospitals 16:18
house 33:6 39:19,20 40:2 50:11
how 5:5 6:5 7:5 9:17 10:18 11:2 12:11 15:19 17:6 19:1 21:20,23 23:22 29:7,8 30:17 32:2 32:10 33:13 36:7 37:3 42:3 44:15 45:8 50:23 57:9,19 58:10 59:20 64:23,23 71:3 72:1,22 73:15,18 80:5 82:7 87:24 88:16
however 6:3 21:12
hundred 36:22
hundreds 38:22,25 39:2 45:1
hurricanes 11:10
hurry 32:11

I

I 3:4,10,18 4:12,14,23,25 5:9,11,12,22 6:1,11,21 6:25 7:2,4 9:5,6,15,17 10:8,12,18,21 11:9 12:20,25,25 13:8,10,21 13:23 14:10,10,13,13 14:23,24 15:3 16:7,10 16:24 17:1,8,15 18:8,20 18:22 19:1,3,4,11,20,22 19:24 20:13,14,18,24 21:16,17 22:17,18,19 22:20 23:1,11,13 24:6,7 25:4,18 26:4,7,11 28:3 28:6,10 29:25 30:3,6,10 30:12,21,24 31:8 32:20 33:9,12,16,20 34:13,14 34:17 35:10 36:5,17,21 36:22,25 37:2,3,11,14 37:14 38:9,12 39:16 40:1,8 41:5,14 43:15 45:3,9,16,21,25 46:10 46:11,20 47:1,1,19,22 47:24 48:6,8,11,14,14 48:15,17 49:4,5,7,10 50:1,4,6,9,17 51:17 52:1,2,2,4,6,16,21 53:11,12,14,16,17 54:1 54:3,7,14,14 55:11,20 55:24 56:2,16 57:4,7 58:19 59:23 60:4,9,19 60:19,19 61:12,17,19 61:20,24,24 62:21,21 63:10,14 64:7,13,14,20 64:22,22,23 65:6,17,25 66:1,3,8,14 67:3,4,5,9 67:11,13,16,16,19,21 68:14,17 69:3,8,12,12 69:13,16,18,21 70:7,12 70:15,21 71:15,20 72:8 72:21 73:8,11,13,14,18 73:18,25 74:6,11,16,18 74:22 75:1,22 76:1,6,18 76:23 77:3,13,18 78:3,6 78:13,22 79:19 80:1,7 82:19,19 83:24,25 84:5 84:11,12 85:8,13,15,24 86:15,15,16,25 87:2,4,4 87:11,17,22 88:1,2,4,7 88:10,13,14,16,16,20 89:12,17,21,21,25 90:7 90:24 92:1,1,5,8,14
idea 30:4
if 6:2,3,4,9,12,17 7:3,15 8:18,20 9:2,17 12:19 15:7 16:19 17:17 18:6 22:18 23:11 24:11 25:11,25 26:3,8,14,22 27:11 29:1,25 30:6,24 32:17 33:12,20,24 34:9 34:10 35:1,6,9 36:2,25 38:3,5 40:18 42:12,17 42:24 43:11 44:15 45:19 46:10,10 47:18 48:6,22 49:15 54:14,14 55:20,21,22 58:24 59:2

59:11,16,18,25 60:3,22 62:3 63:1,18 65:1,8,13 66:23,24,24,24,25 67:15,22,25 68:24,25 69:5,12,12 70:9 73:2 74:11 75:1,22 76:5,8,18 77:25 78:3,13 79:6 80:1 80:15,24 81:11,19 82:10,12,18 83:7 84:7 84:24 85:4,8 87:5,17,25 88:2 89:7
ignore 29:23
image 21:4 77:5
imaged 27:19
imagine 69:21
imaging 57:14,15 75:11 86:17
immediately 35:9 70:24
Immunohematology 73:10
implement 41:11 70:19
implementation 41:4
implementing 70:14
important 17:19 18:10 32:16 60:10,12 74:16 83:4
impression 88:14
in 3:7,24 5:3,10,15,17 6:6 6:7,10,12,13,18,20 7:11 8:16,19,23,25 9:1 10:11 10:14,20,23 11:8 12:18 12:22 13:2,6,9 14:2,5 14:20 15:22,24,24 16:2 16:5,13,25 18:9,11,25 19:2,24,24 20:19,20,20 21:24 22:14,16 23:7,8 23:14,16,24,24 25:11 25:13 26:3,14,16,25 27:4,7,18,18 28:11 29:19 30:6,12,20,25 31:4,11,16 32:11 33:2,6 33:15,25 34:1,13,23 35:2,6 36:2,6,15 37:1 37:13,15,17,20,25 38:8 39:11,14,18,24,24 40:3 40:6,7,8,10,12,13,19 41:3,7,13,17,24 42:1,4 42:23 43:5,5,10 44:6,11 44:16,19,23 45:1,6,6,8 45:15 46:25 47:2,5,7 48:3,6,15 49:3,18 50:10 51:14,17 52:1,6 53:8,13 54:5,9 55:8,16,24,25 56:1,3,6 57:13,17,19 58:15,20 59:1,3,6,7,9 59:10,14,21,23 60:9 61:17,19,23,23 62:1,3,5 62:10,25 63:3 64:3,16 64:24 65:4,9,14 66:13 66:22 67:6,15,19 68:1 68:17 69:18 71:5,13,17 72:12,17,20 73:1,13 74:17 75:1,8,9 76:4,11 77:1,8,21 78:1,2,2,4,5 78:10,21,22,24 79:10 79:10,11,11,16 80:8,21 81:6,9,16 83:10 84:4 85:2,6,6,19 86:1,21 87:2,10,13 88:5,9,12,12 89:12,19,22,23 90:11 92:7,9,9,10,14,14
inception 78:21
incidences 11:6
include 47:23
included 54:9
includes 11:23 81:21
including 10:20
income 30:24
incorporated 46:9
increase 35:7
increasing 38:15
index 27:3
indicate 74:19
indirect 51:7
individual 38:13 41:8
individually 41:9
individuals 71:9
indoor 13:2,3
information 6:14 17:13 18:24 44:2,5 75:4
infusion 33:24
initiate 42:15
injection 23:10
insert 29:1 71:8
inside 11:5,7 50:10 58:11 58:13
insight 5:18
inspect 29:16
inspection 9:4
instead 22:3 34:2 59:7 74:3
instituted 29:12 32:24
instructions 6:16 41:8
instructor 5:11 75:2
instructor's 29:9
instructs 29:2
insurers 49:12
intact 10:5
integrity 81:7
intend 57:4
intended 49:5
intensive 69:21
intent 46:18,19
interest 30:11 65:14
interesting 34:12
interim 11:20
International 1:14
internet 44:8
interstate 18:20
interventional 58:3,9
into 5:18 14:19 17:1 21:6 21:21 22:21 23:5,9 40:12 45:9 50:9 52:8,20 55:4 56:13 57:5 61:1,11 63:8 71:2 77:13
introductions 3:5
involved 8:19 21:10 23:14
ionizing 41:2
is 4:13 5:5,15 6:8,21 7:4 7:11,15,17 8:1,10,24 9:1,3 10:4,7,13,17 11:20,21,25,25 12:9 13:8,15,21 14:18 15:19 16:1,10,17 17:8 18:10 20:1,12,23 21:1,5,14,20 22:14,24,25 23:1,2,5 25:19,22,24 26:17,25 27:2,17 29:18,19 32:16 32:24 33:18,22 34:2,6,7 34:9,10,12 35:4,12,12 35:14,16 37:4,4,19,21 38:1,6 39:10,12,25 40:1 40:2,10,21 41:7 42:6,12 42:15,18,19 43:2,4,13 43:14,15,19 44:3,12,20 44:24 45:12,16,25 46:6 46:7,9,22 47:7,21 49:8 49:23 50:1,8 51:6,21 52:16,23 53:3,5,9 54:4 54:9 56:16 57:16,23 58:8,13,15,18,22 59:8 60:13 61:15,22 62:3,5 62:22 63:11,25 64:7,24 65:4,4,10,11 67:2,21 68:21,24 69:8,20,21,25 70:7,13 71:5,19 72:13 72:14,17,17,19,24,25 73:4,7,23,25 74:1 75:16 76:4,11,14,21,21 77:19 77:19,23 78:14,24 79:6 79:25 81:7,19,23 82:3 84:5,6,6,9,13,15,18,19 84:20,22 85:10 86:11 86:12,17,21,23 87:6 88:19,21 90:5,11,15,17 90:18
isn't 13:2 15:4 31:7 79:15 81:14 90:6
isotopes 36:15
issue 19:22 28:20 29:21 30:5 31:25 32:3,6 39:13 61:21 64:7 70:17 71:20 83:23 86:13
issued 28:23 57:24 58:25 59:15 65:11 72:14
issues 9:6 79:19 89:9
issuing 28:17
it 5:5 6:5,6,12,17,17,18 7:1,5 8:1,15,20 9:13,15 9:18,19,20,22 10:4,21 12:19,20,20 13:2,4,10 14:2,12,25 15:3,8,21 16:17 17:12 18:6,14,15 20:5,9 21:6,14,16,20 22:7,9,10,17 23:21,22 24:14,20,20,25 25:11 25:22 26:9,22 27:22 28:20,21 29:2,7,22 30:3 30:4,6,7,8,18 31:7,12 31:12 32:13,17,21 33:4 33:6,8,14,15 34:1,1,9 34:11,15,16,17,18,19 34:20,23 35:2,2,4,8,8 35:14,16 36:5,6,6,11,12 36:16,19,20,20,21,21 36:23,25 37:1,6,15,16 37:21 38:13,19,20,21 38:22 39:16,21 40:1,3,3 40:17,23 41:5,6,10,12 44:7,12,15 45:9 46:1,4 46:5,8,12 47:7,10,14,16 48:6,23,24 49:4,6,7,8 49:15,17 50:8,8 51:7 52:17,19 53:14 54:25 55:10,11,12,14,15,20 55:22,23 56:1,22,24,25 57:19,25 63:6,7,9,13,15 63:16,16,24 64:5,7,11 64:19,23 65:2 66:1 68:8 68:10 69:17,22 70:9,14 70:15,22 71:13,17,19 72:4,6 73:2,23,25 74:2 74:19 75:1,11,14,24,25 76:7 77:17,20 78:14,16 78:22,22 79:6,16 81:2,6 81:7,8,14,20 82:14,20 83:14,25 84:1,7,7,15 85:6,7,17 86:10,16,21 86:23 87:8,14,16 88:2 88:17,18 90:6
item 6:21 13:12
its 41:16
itself 55:21 73:13 74:19
It'd 8:20
it'll 15:5 56:2
it's 7:6 9:17,18,21 13:2,5 14:7,21 16:8,9,18 20:23 21:2,3,3,15 22:4 23:6 23:12 25:17 26:13 31:7 35:7,9,17,21,21 36:19 38:9,10,17 40:14,15 41:1 42:10 43:17,20,22 44:13,25 45:9 46:10 47:4,17 48:10 49:20,21 52:7,7 53:14,16 54:6,25 55:1 57:20 60:17 62:13 63:1,7,12,15 64:20 66:17,23,24 67:13,20 68:22 69:5,16 70:4,4,5 70:11 71:5,16 73:15 74:6 79:9,12 80:20 81:25 82:10 84:24,25 85:3,3,7 86:9 88:1,14 88:18 90:11,17
I'd 75:3
I'll 4:23 17:24 40:23 76:17 77:15,24
I'm 3:6,11,20,21,23 4:7 18:15,21 19:5,13,20 20:10,13 23:20 24:24 26:8 28:13 38:21 39:12 43:19 51:20 52:10,12 53:4 63:10 64:6 69:3 77:2,16 78:5 80:2 84:5 84:6 88:3 89:23 90:4
I've 22:20 46:20 52:11 58:13 60:8 73:21 87:3
I-center 75:8,9

J

Jacksonville 78:5
James 2:9 3:25 4:24 10:1 70:24 75:13 86:15
Janet 2:10 4:4 5:20 6:25
Janowitz 2:6 3:2,23,23 4:12,16,21,23 6:21 11:1 11:14 12:15 13:5,12 15:18 16:21 17:7,15 19:6 25:4 30:22 31:14 32:23 36:9,12 37:11 38:5,17,22,25 39:7 40:21 48:3,12 49:7,10 49:14,18 50:21 54:9,12 55:7,11,25 56:4,6 60:3 61:5,7,12 64:6 65:1 66:6,9 68:8,11 71:3,11 71:20 76:24 81:11,14 81:23 82:3 83:16 84:14 85:8,13,16,21 86:1,9,12 86:23 87:17 88:3,25 89:9,21,25 90:4,24 91:2
January 42:21 46:15 51:14
JD 2:6
job 15:7,19 17:11 53:18 53:24 63:16
jobs 16:1,8
Johnson 12:9
jokes 8:2
JRC 17:8 68:22
judging 30:10
Judicial 92:6
July 7:8 13:16 22:15 27:20,24 39:20 42:10
jump 78:1
June 8:24 47:5 56:3
just 4:25 6:4,18 9:12,21 13:14 14:23 15:2,23 17:24 18:3 26:13 27:14 30:19,21 31:1,8,12 34:13 35:1 36:4,21 37:6 37:18,25 38:20 41:5 46:21 47:16,17 48:15 48:15 49:2 57:20 60:15 61:10,12 63:4,10,19,22 64:22 65:12 66:1,3 68:13 69:9,16 70:10,13 70:19,21 71:16 74:11 76:3 77:7 80:4,20 83:13 85:13 86:20,22 87:21 88:20 90:18

K

Kathleen 2:5

Kathy 3:13 73:17 78:4,6 81:10
keep 13:25 20:14 32:2 55:4,16 65:4 74:22 77:11
Keiser 3:14
Kennedy 1:24
kept 22:8 37:15 40:13
key 71:12
kidneys 64:15
kind 5:14 12:3 13:14,24 16:6 17:20 23:12 30:8 34:4,12,25 44:7 48:21 48:24 50:9 62:16 65:12 82:10 84:11
kinds 59:18 62:24
knew 80:15
know 3:4 6:3,4 7:5,7 8:13 8:21 9:17,17 10:2 11:7 11:10 13:16,21,23 15:3 15:6,8 16:6 18:7 20:25 25:18 26:1,5 32:10 33:12 36:24,25 40:15 40:16 48:24 49:2,4,6,12 49:18 50:9 52:3 55:21 57:19 59:15,22 60:10 60:19 61:2,24 62:11,20 63:4,15 64:6,18 65:13 65:15,17 66:3,15 67:5 68:25 69:2,3,3,3,18 73:14 74:5 75:4,22 77:5 79:19 80:1,19,22,23 84:20 85:4,8 86:18,20 87:4 88:2,4,9
knowing 53:3 62:23
knowledge 48:23 63:1
known 86:11
knows 77:25
kudos 15:8

L

lab 27:8 36:15 72:25 74:4 75:24
labor 69:21
Laboratories 10:18 21:18 28:8
laboratory 27:10 37:1
labs 10:19 48:22 73:4
Lake 16:14
language 72:10,11
Lantana 8:23
large 9:17,18 17:22 30:5 30:8 45:2 78:3
largest 28:2,6,8
last 13:21 15:23 18:25 19:2,6,12 22:21 25:17 32:21 33:12 39:23 40:9 88:7,16
later 5:15 6:14 21:7 42:13 47:3
Laughter 6:15
law 40:2,20 41:5 51:15 52:8 62:6 67:25 71:6,18 87:25
leaders 9:24
least 6:24 39:16 47:9 50:5 56:13,19
leave 56:14 72:6
leaving 89:25
left 18:20 34:14
left-hand 41:6 72:18 73:4
legislation 39:13,19,22 40:9 42:24 46:4 50:8 54:6 61:18 62:4,16 65:4 66:14,20 70:2 71:13
legislative 41:4 46:18,19 61:25
legislature 9:16 14:1 41:9 41:21 45:4
leisure 76:5
less 38:2 88:18
let 6:3 37:16 63:1 72:13 83:25
letter 35:5,6,7
letters 13:23 15:4 28:18 29:19 59:3
let's 24:12 32:21 58:24 62:22,23 64:10 70:13 79:1
level 12:21 43:19 49:4 50:6 64:3 65:16 80:23
levels 9:19,20
licences 39:14
license 15:3 28:23 31:25 41:19 42:5 43:5 46:2 57:12 59:5 62:7 64:1 65:1,8,11 66:21 67:9,14 67:17 68:13 69:12,24 72:14,15,17,22 73:6,14 73:20,23,24 74:17,18 74:19 75:13 81:11,20 82:25 84:5
licensed 13:18 14:5 42:23 62:3 81:16,17
licensee 32:6
licensees 28:21,24
licenses 13:19 14:5 40:6 41:17 43:10 65:14
licensing 32:7 42:2 68:24
licensure 5:17 43:12 85:10
life 22:16
lifetime 29:6
like 10:9 11:9 17:23 18:6 18:18 25:25 26:2 28:10 29:22 31:19 32:13,21 35:14 36:20 37:7 38:17 38:19 39:25 46:18,22 52:5 58:6 59:6 62:13 65:17 66:17,24 67:21 68:22 73:23 74:1 76:10 79:20 84:12
likely 24:10
likes 18:14,15
limit 35:23,24 69:4 73:12
limited 67:2 84:18
limiting 67:14,17
limits 22:6,7
lined 16:25
lines 11:14 48:21 59:8,10
list 58:2 70:20 73:7,14 76:9 88:10
listed 57:12,16 59:17
listing 74:23
lists 76:9
little 8:11,13 9:7,7 20:18 23:20 25:2 33:17 34:15 51:9 56:20 77:8,13
live 18:11
lives 5:2 24:6
lobbyists 61:21,22
local 9:19,20 10:13
locate 9:2
located 8:22,23 16:19
location 46:7
long 7:5 30:17 32:2
longer 7:18 13:23 37:10 39:17 57:23
look 26:14 29:16 38:5 43:11 46:17,22 52:5 59:2,11,16 60:22 65:13 69:4,11 73:3 80:18 89:17 90:21
looked 33:10 36:20,22 43:8 74:2 80:9,11,21
looking 47:8 62:19 64:14 68:21 69:5,6 75:2 80:12 80:21 90:16
looks 39:25 73:23
loop 55:16
Los 21:18 23:23 25:6
losing 38:18
loss 40:15
lot 7:1 10:9 16:2,3,10 23:18 26:19,23 27:12 36:10,11 47:15 52:18 53:20 60:1 63:25 64:8 64:11 70:5,5 77:12 87:21 88:25
lots 14:2
love 56:10
lovely 7:1
low 13:4 35:22 37:21 80:14
lower 35:21 36:23
lowered 25:10
lucky 9:10
lunch 17:19 18:12 56:12 56:14 61:11 65:20

M

M 1:19 59:7 92:5,23
machine 14:7,11 16:4 23:10 68:24 72:16 75:16,25 86:22
machines 23:21 24:3
magnetic 57:14,15
mail 6:18
main 32:5
mainly 27:8
major 87:6
majority 10:12 14:9 61:13
make 6:10,19 18:3 26:22 46:16,17 47:1 50:4 52:19 55:1,20 63:16 76:20 77:14 79:6 85:6 89:19
making 15:8 54:22
malfunction 23:24 24:3
malfunctioned 24:4
malfunctioning 21:20 23:21 24:2
MAM 59:7
mammo 59:6 61:5 65:24 86:20
mammogram 86:18,18
mammography 44:25 58:21 59:12 60:13 66:16,16
mammos 87:21
manage 27:14
management 2:10 69:13
managers 80:10
mandate 41:12
mandates 41:8
manner 23:24
manual 29:3,9
manufactured 21:11
manufacturer 19:17 21:17 29:3,4 32:7
many 9:18 10:18 16:1 17:3 22:13 25:24 28:20 35:15 36:7 37:12,12 44:15 45:8 49:21 60:2 62:11,11 63:22 64:18 69:24,25 70:13 73:15 73:18 88:17,23
Marion 3:17 16:14
Mark 2:12 4:9 41:25 46:13 57:18 73:12 75:6
Marriott 1:13
master's 43:23,24 50:6
match 34:10 59:4
material 21:2 25:23
math 59:19
matter 11:4 32:5
maximum 38:8 73:12
may 1:9 5:24 8:19,20 9:2 13:16 16:24 32:17 41:25 48:14 52:2,12 53:12 54:20 59:24 60:6 64:19 65:15 69:15,19 69:19 73:12 76:23 78:7 78:8,15 79:21 84:1 87:9 92:16
maybe 6:24 18:3 22:13 33:21 37:18 39:17 48:23 64:14,16 66:3 68:14 69:4
McDonald 5:4
MD 2:6
me 6:3,6,10,17,18 7:1 9:20 18:8 34:18,19 37:22 43:7 46:10 53:9 55:16 60:12 72:13 76:20,21,22 78:16 83:25 86:17 87:3,5,23 88:6
mean 8:15 26:4 28:15 30:24 38:9 48:6 52:2 53:17 63:14 65:7 67:19 67:21 69:16 70:12,15 71:15 73:18 74:6 83:24
means 40:24 71:6
measure 34:5 36:3 54:12
mechanism 82:22 89:7
med 2:5 20:25 47:18,21 47:22 48:2 52:13 54:19 66:25
medical 2:11 4:5 28:23 30:11 37:24 71:24 87:23
Medicare's 88:2
medicine 3:11,24 5:7,12 13:8 14:8 26:6 36:18 39:15 43:13,16,18 47:3 52:19 53:20 54:10,15 55:5 56:18,24 65:7 66:10 68:11 74:13,18 86:24 87:9,15 88:21 89:5
Medicine's 46:8
meet 17:8 41:25
meeting 1:3 14:4 15:23 18:25 33:10 42:7 65:20 65:21 89:10 91:3
meetings 23:18
meets 56:6
member 89:18
members 2:3 86:13 90:21
mention 45:3 76:12,12
mentioned 54:5 61:17 66:13
mentions 42:25
mess 32:22 38:20
messy 23:12
met 9:23
Miami 3:7,24
micro 35:15
microbiology 73:8
microcuries 36:7
middle 12:23 19:2 63:8 73:1
might 10:8,21 26:4 30:6 32:19 42:14 45:5 47:12 50:6 57:11,25 61:1
Mike 18:23 19:14 39:6
mileage 6:4
millicurie 36:8
millions 38:6,23,25 39:2
millirem 28:9
mind 65:4
mine 78:9
minute 26:16 52:1

minutes 4:14,18 19:12
miracles 55:22
missed 22:19 23:11 38:21
mixed 63:8
mixed-use 30:24
modalities 67:1
modified 77:7
molybdenum 36:4,4
moment 77:25
monetary 29:19,24 30:1 30:13
money 14:20 15:12
monitor 37:17
month 11:25 42:13,13 72:12
months 16:16 21:7 27:22 30:18,23 89:14
more 9:7 10:22 16:24 17:23 21:5 24:9,10,11 24:24 31:20 32:19 34:22 36:10,11 49:5 50:4,5,21 52:9,9 54:2 56:20 59:19 61:10 63:16,17,25 70:5 71:2 77:8,25 78:8,16 79:2,14 89:3
morning 3:2,3 4:12 34:14 35:2
most 3:4 29:11 31:12 49:18 66:11 73:6 77:2 83:10
mostly 44:24 77:2 84:4
motion 4:18 85:21
mouth 37:23
move 8:18,25 9:1 11:22 17:15 18:16 41:10 42:24 57:5 76:17,23 85:23,24 90:25
moved 4:19
moving 9:4 10:7,12 15:18 57:5
MQA 2:12,13 13:13 42:1 72:14 73:5
MQSA 61:6,9
MR 3:8,16,25 4:5,9,19,25 5:7,10,14,25 6:13 8:2,5 10:3,7 11:4,23 12:3,17 12:22 13:2 14:13,16 15:11 16:13 17:3,17 18:5,6,10,18 19:5,10 21:13 23:1,6,13,23 24:15 25:18,23 29:17 30:10,16 31:10,20 33:4 33:13,20 34:4,25 35:4 35:12,19,23 36:14 37:22 38:12 39:5,10 40:18,23 43:24 44:25 45:19 47:12,24 49:25 50:4,14,16,24 51:1,3,5 51:6,8,13,20,23,25 52:11,21,25 53:8,11,16 53:20,23 54:1,3,11,14 54:18,21,24 55:1,3,4,6 55:16,19 56:12 57:1,5 57:21 59:24 60:6,10,13 60:16,18,23 61:3,4,10 61:15,17 63:10,18,21 63:22 64:22 65:3,10,12 65:14,22 66:8,10,13 67:3,5,8,13,16,19,25 68:9,12,14,22 69:8,15 69:17,20,22 70:2,7,9,11 70:12,16,18,21 71:5,12 71:23,25 72:2,5 73:10 73:11,15,17,22 74:15 74:22 75:6,11,13,16,18 75:19,24 76:25 79:9 81:10,13,15,25 82:5,6,7 82:16,18,25 83:2,4,6,14 83:19,21,25 84:17 85:12,18,23 86:4,7,8,10 87:2,19,22 88:7,14,20 89:5,11,15 90:5,7,14,17 90:20,25
MRI 59:12 65:24 66:16
Ms 3:10,13,20,21 4:2,4,7 4:15,20 5:6,9,11,22,24 6:1,16,23 7:25 8:1,3,4,7 9:12,13,14,15 10:4,6 11:16,17 12:1,2,8,18,24 13:3,6,14 14:7,15,17,23 15:10,21 16:23 17:8 18:3,8,13,14,15,16,22 19:8,11 21:14,15,16 22:24 23:4,8,11,19 24:3 24:5,9,17,23 25:9,13,15 25:16,22 26:7,10 29:21 30:3,15,17,19 31:5,7,8 31:16,18,22 32:11,12 33:1,5,16,24 34:6 35:3 35:5,16,17,21,25 36:11 37:8 38:2,19,20,21,24 39:2,6 40:17 43:22 45:18 47:4,14 48:1,5,6 48:14 49:8,12,17,20,21 50:1,12,17,19,23,25 51:12,17,22,24 52:10 52:12,15,18,24 53:7,12 53:19,22,25 54:16,23 55:9,13,18 56:2,5,8,9 56:10,16 57:4 60:8,15 60:17,22 61:4,6,8,16 63:24 65:19 66:12,23 67:7,12,14,18,21 68:20 69:10,16 70:4 71:24 72:1,4 73:21 74:13,21 74:25 75:8,22 80:3 82:9 82:17,24 83:9,15,20 84:24 85:15,24,25 86:3 86:5,15,25 87:20 88:1,5 88:13,16,18,23 89:2,8 89:11,12,17,23 90:2,11 90:13,15,19,23 91:1
much 20:24 24:7 28:22 29:11 41:2 59:12 61:8 72:22 86:10
multiple 31:24 59:13,16 74:5 78:1 80:19
must 17:24 33:22 77:21
my 15:24 18:9,13 32:24 36:6 37:18,23 43:7 53:1 53:5 55:17 63:5 70:12 83:7 86:23 92:12,14
myself 25:24 87:22

N

N 2:1
name 7:22,24 12:13,14 21:12 41:18 46:1,2
named 8:12
Nancy 3:20 5:3,14 45:16 47:1 55:17 56:15
Nancy's 44:11
narrow 54:23,24,24 55:1
national 21:18 28:8 40:5 41:15,22 42:7 43:2 44:18 45:23 47:4 66:22 68:15 71:3,5,6 74:5 75:20 79:25 82:14 83:3 83:11,20
nationally 45:15 88:10,19
nationwide 89:2
NCOR 52:17
NCT 44:6,13,18 45:17,23 46:7 47:17,21 48:10 51:20,21 56:20
necessarily 78:5
need 9:19 20:15 32:1 40:19 42:2 46:20 47:23 60:24 61:9 63:11,15 65:1 74:23 81:5 84:21 89:13
needed 41:11 42:12 76:2
needless 17:4 22:11
needs 42:4 64:8 75:11
neither 45:24
neutrons 41:1
Nevada 19:18,24 20:8,20 21:22 27:1 28:10,13 37:24 38:8
never 36:6,19,21 49:12 50:10 62:9
new 5:16 10:16 11:17 12:4,5,6,16 14:23 15:19 16:2 28:23 29:12,25 31:25 33:24 34:23 39:4 40:12,12,18 42:4,22 50:1 52:20 68:9 71:1 74:1 75:2 79:11,11 86:13
news 9:7,8
next 6:21 8:10 13:12 14:4 15:7 19:25 20:11,14 23:19 26:12,25 32:4 41:3 63:3 64:3 66:16 72:12,13,24 73:9 77:19 78:25 79:3,14,20 89:10
nice 40:17 44:5
nicer 15:5
nine 28:6
NMAA 50:1
NMTCB 40:6 43:4,9,11 44:2 45:12,21,23 46:22 52:13,16 55:12 56:14 72:9 74:7 88:7
NMTCB's 5:18 44:9 46:7
NMTs 89:1
no 7:18 11:4 13:6 23:7,8 24:17,17 26:19 29:21 30:24 34:22 36:19 39:3 39:4 47:17 48:3 51:22 54:9 56:16 57:18,23 58:14 65:11 67:6,13 69:10 70:15 74:25 75:16 79:9 84:17 90:13
nobody 36:3 48:1
nobody's 49:15 53:17
None 4:22
noon 34:19,19
normally 25:19 72:15
not 6:10,24 7:5,23 8:18 8:20,20 9:2,8,10 11:11 11:16,17 12:20 13:5,6 13:10 16:1,9,11,17 17:20 19:4,5,23,24 20:23 21:19 22:4,7,8,9 24:18 25:1,7,16 26:1,11 26:23 27:13 28:13,19 28:21 29:10,21 30:4,14 31:12 32:13,14 33:7 36:5 37:17 38:9,10,17 40:7,10,13,15 45:2 47:18 48:5,11,14,19 49:20,21 52:7 53:3,3,6 53:14 54:24 56:24 57:18,19 58:20 59:9,22 60:2,10 61:14,20 62:14 63:12,13,13,15 64:6,9 64:19 66:17 68:10,18 69:4,10,10 70:5,5,15 71:16,21 72:2 75:19 76:2,12,13,21 77:16 78:5 79:7,18 80:20 81:12 83:3 84:6,19,22 84:24 85:3,5 87:9 88:3 88:14,20,23 89:19 90:7
Notary 92:24
note 37:9 57:23 58:4
notebooks 6:2
notes 19:20 58:9
nothing 10:3 14:13 26:5
notice 28:17 42:11 44:20 70:22 71:1
November 80:8 89:13,18 89:19,20,22
now 4:23 6:4,17 7:9 8:2 10:11 11:17 15:12 19:1 20:18 22:20,24 24:20 27:2,17 28:9 29:14 33:2 33:12,14 35:10 40:23 41:23 52:2,21 53:5 59:14 62:9,14,18,19,21 64:7,13,20 65:14 66:4 68:22 72:3,6,7 73:23 74:6 82:21
nu 66:25
nuclear 3:11,24 5:7,12 14:8 31:22 32:1 36:17 39:15 41:1 43:12,13,16 43:18,25 44:4 46:8 47:3 47:16,18,21,22 48:2,13 48:25 49:3,14 50:5 52:13,19 53:20 54:9,15 55:5 56:17,18,24 60:4 65:7 66:10 68:11 74:13 74:17 86:24 87:6,9,15 88:21 89:5
number 22:3 26:20 28:11 45:11 49:22 60:5 77:11 77:20 78:18 84:8 88:9
numbers 13:15 26:23 32:18 33:13 44:23 45:2 45:14 58:25 59:11 62:19
numerical 79:15
nuts 82:20

O

Oak 28:7
objection 60:20
Ocala 18:9,11,14,15
occur 58:20
occurred 28:20
October 27:18 39:23 80:8 89:13,16,24 90:1,9,10
of 1:1,2 2:8 3:4,14,17,18 3:23,25 4:1,2,10,13,13 5:1,2,12,13,16,18,18 7:6,10,11,12,14,17,18 7:20,23 8:9,13,21,25 9:1,5,6,12,16 10:9,13 10:16,17,17,24 11:8,8 11:25,25 12:3,10,10,11 12:25 13:7,7,14,16,17 13:18,24 14:2,9,11,12 15:1,12,13,15,16,19,21 15:25 16:2,5,6,8,10,12 16:21,24 17:19,22,23 19:2,18,22,23 20:3,18 20:24 21:10,17,24 22:1 22:3,4,6,11,14,15,16,23 23:12,15,16,18 26:5,10 27:12,12,24,25 28:1,5,8 28:17,17,20,25 29:11 30:8,8 31:3,6,12 32:2,7 33:1,7 34:4,12,25 35:13 35:17 36:7,24 37:12,12 37:16,19,20,23,25 38:6 38:7,15,22,23,25,25 39:2,2,3,7,13,14,21,22 40:9,11,21,24 41:16,20 41:22,25 42:8,9,10,11 42:18,19,25,25 43:3,9 43:12,16,19 44:4,6,7,12 44:14,16,16,18,19,22

44:25 45:2,14,16 46:3,6 46:7,9,20,21,22,23 47:2 47:3,10,15,15 48:4,12 48:20,21,24 49:22 50:7 50:9,17,19,22 51:11,19 52:2,18,18,19,20 53:1,9 53:20 54:10,19 55:5,20 55:25 56:17,18,20,21 56:22,23,23 57:2,3,6,8 58:4,5,7,21,25 59:7,13 59:13,14,18,18,20,24 60:1,2,5,8 61:13,25 62:4,6,15,17,21,24 63:5 63:7,8,16,23,23,25 64:8 64:11,15,17,18 65:12 65:24 66:1,19,23,25 67:5,10 68:8,20,21 69:14,17,25 70:5,5,14 70:15,16,17,19 71:1 72:10,14 73:4,6,18,22 74:3 75:10,19 76:1,3,10 76:13 77:2,11,12,14,17 77:18,20 78:2,7,8,11,11 78:12,13,18,21 79:1,4,5 79:21 80:24 81:8,18,22 82:10,11,20 83:10,17 84:8,11,11,20 85:1,2,7 85:7 87:3,5,6,6,11,21 88:9,10,25 89:15,23 90:1,10,21 92:2,3,6,6,6 92:12,12,15,15,15,16
off 15:18 20:4 37:15 51:9 63:4 65:25
offended 18:15
offer 57:8
offered 57:9
office 4:10 11:7 14:18,19 14:21 31:1 33:23
officer 31:11,15
offices 8:22 31:19 64:11
official 7:6 42:11
often 31:24
oh 6:23 9:18,19 14:15 18:5 20:11 22:4 28:13 30:9 32:19 56:10 65:13 67:7 71:25 73:17
okay 6:23 8:3 13:12 17:15 19:8,14,25 20:11 20:17 21:16 24:1 26:11 26:14,20,24 28:14 29:22 32:4 36:18 40:1 46:6 49:25 51:23 52:14 52:25 54:3 55:18 56:10 56:11 60:1 61:10 62:9 67:7,18 68:20 72:5 73:22 76:23,25 78:1 79:13 90:13,23
old 24:17,18,21 79:11 86:12
older 36:10
on 2:3 5:13 7:9 8:9 10:22 11:21,22 12:22,24 13:12,15,24 15:12,21 16:18 17:12,15 18:12 19:8 20:15 21:20 22:9 23:20 26:4,15 27:2 28:4 30:5 31:21 32:13 33:4,6 35:23 38:6 39:20 41:6 41:19 42:6 44:3,10,14 45:8,13 46:2,7,12 48:18 48:22,23 52:14,15 57:11,22,25 59:4,5 66:21 67:9 69:23,24 70:5,17,22 72:16 73:3,6 73:11,19,23,24 75:4,13 76:11,17,17,23 77:6,22 77:23 78:6,17 80:3,7 82:13 84:22,22 89:14 89:16 90:4
once 35:2 37:11 69:18 73:13 76:25
oncology 30:25
one 5:3 8:21 10:17,20 12:22,24 14:13 17:21 23:13 24:6,13 25:4 26:10 27:15 28:10,12 28:25 31:14,17,20 33:11 34:12,14 37:12 40:8,13 41:15 42:18,19 43:2,13,15 44:3,6 45:16 45:24,24 47:17 49:14 50:23 51:10 52:14 57:10,22 58:7,11,12,18 61:12 66:11,15,25 68:21,23 69:13,13 70:18 72:17 73:9 76:4 78:7 80:20 81:18 82:14 82:15 84:10,25 85:3,6 87:3 88:3,5
ones 57:9,12 59:3 62:23 66:4,4 67:4 72:9 73:19 74:7,13
one's 72:17
online 14:24 15:2 42:3 73:24
only 13:20 19:24 22:8,15 29:23 31:2 37:1 44:22 47:22 48:7 53:12 54:4,4 59:17 62:20 67:4,23 68:2 69:25 73:21 76:12 81:15 83:2 84:17,18
onto 48:15
open 16:1
openings 16:10
operative 71:10
operator 14:7 72:16 75:17,25
operators 14:11
opportunity 55:21
opposed 4:21
opposition 50:7 61:23
or 4:16 7:8 11:2,15 12:11 12:20 13:10 16:17 17:10,21,24 21:11 23:15 24:16,19,25 26:20 29:9,9,18,23 31:11,12 34:7 35:14,16 36:14,25 37:5,6 40:6 45:5,24,24,24,24 46:8 48:9 50:13 53:1 54:1 56:21 57:21 58:12 59:13 60:20 62:14 63:11,13,19,24 65:12 65:23 66:25 67:19 69:13,18,19 71:7,9,9,22 72:12 73:5 74:18 79:9 79:19,19 80:8,21,23 81:17 84:15 85:6 86:12 87:13 88:10,10,17 89:2 90:9,17,18
order 4:13 23:16 42:4 77:22 79:16
organization 40:5 41:15 45:23 71:4,5,6
organizational 7:4 9:6
organizations 41:23 42:7 43:2 74:6,9,11
originally 27:19
Orlando 18:25 27:7
other 3:4 7:13 8:8 9:5,5 9:10 10:8,22 11:9 13:20 13:25 15:25 17:7 19:8 34:24 41:1 43:4 45:24 50:23 52:1 60:20 61:12 62:15 65:3 66:23,24 67:1 68:21,25 69:14,16 73:19 74:7 76:10,19 79:9 81:6,6 89:9
Otherwise 6:18 19:11
ought 65:25 66:14
our 7:4 8:17,22 9:1 10:23 11:7,23,24 12:14 13:15 14:2,10,18,21 15:15 16:2,8,16 18:23 27:8,9 27:16 28:4,17 43:3 46:17 47:6 51:14 52:5 61:21 78:24 79:24 81:23 82:1 83:20 85:1
ours 81:21
out 5:1,2 6:4,5,17 8:2,16 9:12,24 11:10 13:17 14:4 16:23 21:23 23:16 24:14 25:21,22,23 28:5 29:19 33:16,21 36:17 36:25 37:1,16,17,23 41:9 52:18 53:17,18,23 55:19 64:3,9 65:14 72:22 76:6 77:9 79:4,5 79:21 80:7 82:11 83:10 87:24 90:20
outpatient 16:2 31:12,16 31:18 86:22
outside 59:10 68:8
over 4:23 14:1 22:5,6 24:10,10,22 26:16 42:24 43:10 44:15,24 46:17 57:5 58:24 66:2,2 66:2 77:7 80:16
overall 38:15 58:16
overlap 74:8
own 10:23 25:6 60:13

P

P 2:1,1
pack 61:10
package 28:25
packet 6:7,10 39:24
packets 6:1
page 7:9,15 8:10 12:24 44:14 45:13 57:6 59:4 72:24 76:11
pages 33:19 41:5 44:3 92:11
paid 30:13,15
paper 73:13
paragraph 44:4,6,9 87:11 87:12
Paramedics 4:7,11
Pardon 43:7
parenthesis 59:3,7
part 8:21 15:21 40:13 59:20 60:12 62:5 71:12
particles 40:25 41:1
particular 41:4 50:7 61:21 79:1 86:21
parts 10:24 62:15 85:4
party 48:8
Pasco 92:3,7,15
pass 36:10 68:12 79:8 82:16,17 87:25
passage 39:12 81:21 83:17 85:11
passed 39:20 40:2 51:15 53:14 81:12 88:17
passing 37:14 77:22,23 78:14,14,24 79:10 80:14,15 81:4 82:13 83:18
past 24:5 25:11 29:6 39:11,18 83:25
path 51:9 70:25
pathway 43:18
patient 21:4 23:3,4,5 26:19 27:21
patients 20:7,8,9,19 21:7 22:9,11,14 23:15,16,17 24:12 27:2,4,6,12,13,15 27:16,18,19 28:1,6 34:22 37:5
patrol 20:1,4 21:9
Paul 2:5 3:8 37:19
pay 18:9 48:9 70:10 73:16
payers 48:8
paying 88:2
PEM 86:17
penalty 30:13
Penny 1:19 92:5,23
people 10:23 11:8,12 16:25 17:4 20:25 24:24 25:11 26:7 31:5 37:8 38:7,8,16,18 42:22 45:2 45:5,8 47:22 48:18,23 48:25 49:1 53:12 54:18 59:17,20,22,24 60:1,23 63:12,25 64:8,16 65:15 69:9,19 71:2 73:16 74:21 75:1 80:10,10,13 81:8,11 82:9 83:10
per 36:7 70:3 73:16
percent 16:8,15,16 21:2 35:19,20 59:19 79:5,8
percentage 35:13,13,16 80:24
perfect 20:17
perform 54:1 63:16 87:9
performed 10:13 25:7
performs 43:3
perhaps 42:19
period 22:15
permission 46:10,11
person 26:3 33:6 34:18 50:3,6 57:7 70:9 73:7 73:24 79:20 87:8
personal 52:7
persons 33:9
perspective 10:21
PET 20:7 43:1 45:24 47:2 47:9,11,20 49:22 51:24 52:1,22 53:6,14,17 54:4 54:9 56:22 66:6 86:18 86:20,22 87:17,20 88:9 88:12,17,23
Pete 88:5
PET's 66:13
pharmacy 4:10 31:22,23 32:1
phased 70:22
phone 34:14
phrase 46:24
physical 8:18 69:24
physician 50:22
physicists 87:23
physics 64:3
pick 17:5 51:25 90:8
picked 15:24 20:3 25:12 78:24
picking 20:6
picocuries 36:22
piece 50:7
pieces 9:7
place 7:7 14:2 18:2 19:23 31:11 37:1 65:17 69:2
placement 16:15 17:11
places 16:4 17:21 44:7 71:17 88:23
plan 9:24,25 41:4
plant 37:16
play 21:21
plenty 15:19
point 15:5 22:20,22 23:13 37:11 45:20 47:23 48:12 49:9 51:21 53:1 66:19,20 74:12 75:20 78:2

pointed 87:24
policies 75:21
pool 16:21
pops 40:19
population-wise 16:17
portion 56:22 66:7 70:14 72:19 87:6
portions 85:7
position 43:21,22 53:5 56:16 70:13
positions 16:11,11
positron 34:7 43:14 44:1 45:12
possibilities 52:21
possibility 48:7
possible 28:22 54:4 63:1 69:18
post 17:11 41:16 44:23 57:16,21 58:16
potential 37:20
pound 84:2
PowerPoint 80:4
practice 41:20,22 42:9 46:3,6,22,23,24 47:10 47:10,15 48:4 50:18,20 51:11 52:2,19,20 54:10 56:21,21,23 58:7,18,20 60:14 63:6 70:16,19
practices 49:22
practicing 5:7 54:19 62:8 84:4
preface 61:20
Preparedness 7:20 8:9 10:16 11:1,9 12:10,12
present 78:10
presentation 19:3,19
presented 81:3
presents 55:21
pressed 30:8
pressure 29:23
pretty 14:11,16 16:13 19:3 29:11 30:13 32:25 33:11 41:2 47:16 59:12 61:8 74:6 86:10
prevent 7:25 28:22
preventing 8:5
Prevention 7:23
previous 39:22
primaries 58:17
primary 41:16 43:4,5,9 44:23 57:12,16,21 65:6 67:1
print 33:21
priority 37:4 64:20
private 64:11
privately 88:2
probably 7:8 15:14 16:7 18:16 22:12 25:16 32:23 36:19 38:2,10,22 38:24 45:10 47:14 50:16,21 53:5 62:20 84:2,3
problem 31:6 34:3 36:19 63:7 72:3 90:9,13
procedure 36:18
procedures 30:23 54:1 87:10
proceeding 62:22
proceedings 3:1 92:9,12
process 8:25 9:1 14:18 15:1,9 42:14,20 46:16 52:23 71:15,16 80:20 81:2
processes 80:20
processing 14:14
product 20:23 35:14 36:1
production 77:5
profession 17:1 41:19,20 46:25 72:25 73:5 75:14 81:9
professional 71:7
program 3:16 5:12 15:23 18:24
programs 17:10 68:23 69:1,1 71:10 89:6
prohibit 62:6,7 64:25
promulgation 42:11
pronounce 5:5
properly 25:1
proposed 7:16 42:16
proposes 70:2
protection 2:3 77:5
provide 17:20
provided 6:11 27:3 87:10
psycho 85:2
psychology 77:13
public 10:18,19 17:13 92:24
publish 17:9 42:16
pull 25:20 52:18 55:9
pulled 20:12 47:14
purpose 50:8
purposes 68:2,19
pushback 50:14
pushed 51:1
put 6:19 14:2,20 18:23 20:15 43:10 46:12 48:6 53:1 55:23 59:7 64:11 69:24 72:10,15 77:8 83:25,25
putting 6:25 16:18 19:14
p.m 65:21 91:3
P32 36:16

Q

QA 32:25
QA/QC 37:4
QC 24:25 33:2
qualification 74:2
qualifications 73:2
qualified 64:10 77:16 81:9
quality 2:11 48:20,24 69:13
question 26:4 37:18 47:25 68:15,19 78:3 80:25 82:8 83:7 84:25 85:18 87:24
questioning 80:13
questions 6:3 9:11 39:6 45:19 57:8 58:10 67:3 77:4,9,10,12,20 78:6,10 78:11,15,18 79:3,4,14 79:19 80:9,22 84:11
quick 58:19
quickly 18:5 21:3 27:9 47:17
quite 28:12 39:11 84:10

R

R 2:1 92:1
RA 51:9,14,19
rad 4:8,11 62:17 74:1
radiation 1:2 2:3,8 3:14 3:21,25 4:2,4 5:2 7:10 7:23,25 8:6 10:9 11:5,6 13:9 14:8 19:18 20:2,5 21:8 31:10,14 38:2,15 40:11,22,24 61:19 62:5 62:7 66:25 67:22,24 68:1,3,4,8 77:5 87:10 87:12
radio 36:15
radiographer 14:8 72:16 87:9 88:11,21
radiographers 14:10 54:19 55:2
radiographer's 65:8
radiography 39:15 58:3 65:7 77:8 87:7
radiologic 3:17,18 11:2 39:14 43:2 62:25 65:6 74:3 75:15
radiological 11:11
radiologist 43:20 58:23
radiology 3:14 48:18 50:3 50:15,24,25 51:1
radon 12:17,18
rads 60:4
range 43:9
rate 16:15 20:24 78:12
rates 17:11 24:11
rather 10:24 24:14
rating 85:1,1
ratio 35:17 36:7
raw 81:5 84:14,18
rays 40:25
RDCS 76:15
read 7:2 19:11 33:14 40:23 73:9 87:11
reading 25:20
ready 53:21 90:24
real 72:15,22
realize 20:14 32:15 36:9 64:13
realized 28:19
really 9:8 21:19 27:2 43:17 44:5,22 49:8 54:22 64:9 66:19 69:4 70:11 74:8 76:2 79:12 80:11,15 81:7 89:19
reason 29:23 61:22 62:3 70:15 82:3
recall 22:18 51:13
recalled 21:10 27:25
receipts 6:20
recently 80:4
recess 39:9
recessed 65:20
recognition 49:5,7
recognize 40:5 41:14 45:23 49:1
recommend 47:8 62:22 70:21
recommended 24:12
record 22:5 32:12 75:10
recorded 22:4
recording 22:2 28:18 72:5
records 20:9,10 26:21
red 59:3
rediscovering 90:8
refer 56:25 60:15
reference 46:9
referred 77:23
refers 71:14
reflect 66:21
reflected 79:11
reflective 35:4
refresher 29:13
registered 58:23 76:15
registers 71:8
registries 66:22 76:10
registry 51:10 68:15 71:7 75:20 76:13,25 79:25 80:3,9,12,16,21 81:3
regs 87:2
regular 24:17,18 82:13
regulate 40:19 64:23
regulated 73:5
regulation 40:11 41:18 45:22 50:22 52:6 78:24 84:21,22
regulations 10:15 46:13 52:8 60:22
regulatory 2:13 22:6,7 46:16 52:3,5
reimbursed 88:1
reimbursement 61:1
relate 57:9
related 9:11 67:23 68:2 71:10
relations 57:7
relative 78:12
release 15:16
relevant 62:13
rem 28:11,13,13
remaining 43:25
remember 28:11 61:17 71:20,23,24
Rena 12:19 13:1
renegotiating 15:15
renewed 13:18
renewing 57:25
reorganizational 9:23
repeat 34:18 35:8
repeated 34:11,19
replaced 58:1
report 7:19 22:7,10 84:17 92:9,12
reported 1:18 32:18 78:19
Reporter 1:19 92:5,24
reporting 1:23 28:19 32:16 33:13
represent 3:18
representative 47:6
represented 3:10
reproduce 19:20
request 33:2 89:17
require 49:15
required 11:7 22:10 42:18 63:15
requirement 29:12 63:11 81:14 85:10
requirements 32:7 61:9 66:17 81:18,21 85:9
requires 41:21 61:7
requiring 49:11
rescanned 37:6
resonance 57:14,15
response 11:2,6 12:11 67:11
responsibility 43:20
responsible 41:12
rest 37:25 44:12,25 54:19 55:5 57:3,21 60:2 76:1 84:8 87:11 90:21
restructuring 6:22
result 33:1 83:1
results 22:1 34:11
retain 85:18
retired 3:12 31:8
retiring 11:25 12:2 89:4
return 6:11
revenue 70:12
review 2:10 33:5
reviewing 33:7,11
RIA 54:17
Richardson 2:6 3:16,16 16:13 17:3 18:6 34:4 75:13,18 82:6 83:2,6 86:7 89:5
Ridge 28:7
right 5:14 7:9 8:7 10:11 15:12 16:15 17:25 20:17 22:18 24:20 26:11 27:8 33:2,12 34:21 37:5 39:10 40:23 45:17 47:1 53:5 54:11 57:1 59:17 60:5 62:21 63:21 64:7,20 66:12 67:2,15 70:18 72:3,8 74:6 76:1 78:1 79:14 83:15 85:21 87:16

90:14
right-hand 72:20
road 48:8 49:13 50:2 62:11
role 51:14,18
room 37:15
rough 34:25
roughly 42:12 43:19 79:5
round 52:22 63:3
roundabout 9:21
RRA 58:22
RT 2:5,6 71:21
RTs 89:1,6
rubidium 17:16 21:1 22:25 31:3 35:18 48:9
rubidium/strontium 20:21
ruin 24:19
rule 42:11,11,16
rulemaking 42:15 70:23 70:25
rules 52:8 71:1
RVT 76:14

S

S 2:1 57:20
safest 52:25
safety 31:11,15
said 23:21 26:25 32:4,19 34:18,20,21 48:22 61:25 62:12 67:5 72:2 73:12 78:22 87:22 92:12
sales 39:3,4
saline 24:9,16,18,18 36:11,12
salt 24:7
same 8:6 31:25 34:24 36:1 37:15 43:19 45:10 46:2 50:2,14 52:16 68:11 72:16,24 73:3 74:23 75:3 76:8 77:12 78:6 79:25 80:6 81:4,25 83:7 84:12 87:22
sampling 23:16
sand 84:2
Sarasota 15:25 27:4 34:13
sat 33:9 48:18
save 66:4
saw 33:16 36:6 39:22 40:9 67:11 76:3 78:6
say 4:25 10:3 13:10 14:23 16:7,9 17:5,24 21:12,16 22:11 24:12,25 25:17 28:7 30:9 37:3 46:6 48:8 52:7 54:15 56:2 57:20 59:23 61:24 62:3 62:20 64:12 67:16 74:3 75:25 78:13 79:2,21,22 79:23 80:1,2 90:22
saying 32:1 34:14 61:20 68:17 69:3 84:6,6
says 16:23 20:9 32:13 35:6,8 41:7 45:22 46:5 62:16 66:5 75:14,24 87:8,16
scale 30:5,8 78:19,20 84:16,17,22 85:19
scaled 77:24 79:25
scan 27:16 37:13 38:4 48:9,9 53:14 54:17,17 75:9 86:20
scanned 22:12
scanner 30:25 88:24
scanners 38:17
scanning 21:3
scans 20:7,21 28:16 37:9
schedule 39:7
scheme 79:11,12
school 3:17 82:11
schools 13:22 17:14 71:21
scope 41:20,21 42:9 46:3 46:6,22,23 47:9,15 48:4 50:17,19 51:11 52:1,19 52:20 54:10,15,20,22 56:21,23 70:16,19 84:19 87:6
scopes 76:2
score 77:21,22,23,24 78:14,14,19,19,20,24 79:15 80:1,5 81:4,4,5 84:14,16,17,18,22,23 85:19
scores 80:14
second 4:20 24:13 42:6 43:14 45:7,12 57:17 85:25 90:9 91:1
seconds 22:25
Secretaries 12:5
section 5:18 13:1,9 55:13 57:17
Security 25:5
see 3:3 7:3,9,13,21 8:7,10 12:19,20,20 13:4 16:10 17:13 23:11 25:1,25 26:3,15,22 35:7 38:10 40:1 41:3,6,24 42:17 44:12,17 45:14 49:7,10 52:14,21 54:14 57:10 57:13,25 58:24,25 59:2 59:8,12 60:2 63:10 64:22,23 65:13 72:20 72:21 73:1 76:5,11 78:6 90:22
seeing 32:19
seek 45:5
seemed 29:10 32:10
seems 29:22 32:6
seen 9:18 15:25 17:1 20:24 23:1 65:23 82:20
SEMI-ANNUAL 1:3
Senate 39:19
send 33:6 55:19 90:20
sending 15:4 68:18
sends 33:2
sense 50:5
sent 14:21 29:5,19 32:15 81:17
sentence 87:15
separate 18:4,5 68:24 81:23
separated 76:6
separately 57:17
September 56:1,7 90:12
series 57:8
services 10:9,23 83:22,22
set 10:15 20:4 26:9 29:7,7 29:7,8 40:3 92:14
setting 37:15
seven 30:19 82:20
several 10:19 48:16,17
shall 17:23
shape 67:19
she 18:10 33:10 34:18,20 36:16,25 78:7,15,16
sheet 6:8
she'd 36:17
she's 9:1 47:7 56:10 73:18
shoot 55:17
short 23:6
shorthand 92:9,12
should 8:15 13:10 23:19 25:1 28:7 34:17 35:8 45:3 48:3 55:7 56:23 61:19 64:14,21 66:1,3 73:18 80:22,23 83:23 85:13 86:16
shoulder 46:17
shouldn't 52:7 59:23
show 17:23 72:11,13,21
showing 8:11
shows 44:15
shut 31:2 34:21
sic 89:19
side 7:15 37:24 41:6 52:1 69:16 73:4,22
sides 16:5
sign 6:8
significant 38:13
sill 89:3
similar 58:15
simple 74:7
simply 22:3 46:5
simulation 68:2
since 7:18 15:18 46:5 77:24 78:20 82:1,1 84:3 87:2
single 47:19
sir 5:6 45:18
sister 10:17
sit 5:12
site 20:13,13 27:3 29:2 33:2 34:23,24 73:24 80:3 86:21
sites 22:2,4 24:23,24 32:8 34:13
situation 15:19
six 16:16 30:23 53:12 79:2,4
Sixth 92:6
skip 20:10
sleep 43:7
slide 19:25 20:10,11,14 20:17 23:19 26:12,17 32:4
slides 18:22,23 19:8 26:15
slight 7:22
slightly 59:5 79:16
small 14:18 88:23
smaller 43:9
smooth 15:1,9
smoother 15:5
SNM 56:6
snow 27:14
so 4:12,19 6:13,16 7:18 8:4,24,25 9:11,20,22 10:1,15,20 11:11,16,17 11:18,20 13:22 14:3,12 14:16,21,25 15:16 16:3 16:4,16,21,24 17:1,4,12 17:23 19:20 20:18 21:3 21:10,20 22:8,11 23:6,7 24:11,21 25:11 27:2,7,8 27:10,17,17,23 28:15 28:19,20 29:7,15 31:4 31:25 32:8,15 33:11 34:25 35:14,19 36:18 37:25 38:8,9,21 39:5 41:1,3,23 42:17,24 43:8 43:10,24 44:7,8,12 45:1 45:5,19,20 46:20 47:19 47:22 48:21 49:25 50:21 51:20 52:21 53:4 53:4,14 54:1,6,7,12,25 57:5,25 59:22,25 60:8 60:11,11,15,19 61:1 62:17,21 64:3,5,15,19 65:12,13,22 66:14,17 68:18 69:24,25 70:4,9 71:11,15 72:6,12,21 73:7,11,11,11,25 74:22 75:9,18 76:12,17 77:6,6 78:13,17 79:5,15,18 80:18,20,24 81:9 82:3 82:18,22 83:23 84:19 85:3,5,6,13,21,24 86:20 87:14,15,17 88:13 89:6 90:7,15,17,20
societies 46:23 76:19
society 3:18 46:7,8 47:3 51:11 55:14 56:17,18 56:23
solution 69:23
some 5:18 10:21 11:8,11 11:12 13:15 15:13,25 19:22 20:12 21:22 24:1 24:21,21,23,24 26:5,7 31:5 32:24 44:2 45:7 50:7 58:9,9,10 59:5,24 61:23,25 63:14 66:23 71:21 73:12 74:21 76:9 76:13 77:9,18 80:22
somebody 19:17 48:10 53:8 66:4 69:5 77:25 89:7
somehow 55:21
Someone 33:14
something 25:2,2,25 29:24 30:7 33:14,20 35:25 38:10 39:25 40:18 44:20 52:11 53:1 53:8 54:6 64:20 66:18 71:22 79:20 90:20
sometime 72:12
sometimes 37:9 38:9
somewhere 14:10 33:15 79:10 88:8
sonographer 76:16
sonography 57:14,15 58:15,15,17,17,19 60:24 61:4,13,23 62:1 62:14,18,22 63:2,6,19 64:1 65:10,12,15 67:5 74:10,10 76:8,10,11
soon 15:17
sooner 32:17
soonest 47:12
sorry 18:21 20:13 28:13 38:21
sort 26:5 64:15 68:20
sound 22:17 58:6
sounds 65:17
soup 58:6
source 31:3
sources 71:10
southeast 47:6 90:11
space 9:2
span 22:16
speak 61:20
speaks 87:12
spec 25:21
special 40:3
specialist 2:10 9:1
specialists 48:18
specialized 69:6
specialty 40:4 41:17 42:8 47:11
specific 75:18 76:13
specifically 42:25 54:5
specifications 77:1
specificity 52:6,9
specify 45:25
SPECT 48:9
speed 40:25
spelling 72:22
spent 70:5
spoken 39:11
spot 44:6
spots 17:4
St 88:5
staff 2:8,11 8:17,23 9:4 10:4,14 29:14 57:18

61:25 69:25 75:6
standard 34:9 56:22 58:8 58:18,20 60:14 63:7
standards 10:15 46:23 47:10 86:19
standpoint 46:20
start 3:5 9:13 11:21 19:25 29:14 30:20 35:6 42:8 42:10,21 44:21 46:14 47:8 53:5 56:8,13 62:23 64:13,14 65:15,25 70:14,14,23,25 71:1 74:9,23 84:1
started 3:3 9:15 18:22 27:5 28:17 30:19,20 50:12 56:9,10 68:23 75:21 89:4
starting 58:5
starts 19:2 45:13 73:2
state 3:8 10:20,24 11:17 15:21 35:10 43:3 59:14 65:11,16 66:21 69:8 82:1,6,15 83:2,10,13,16 83:18 84:5,10 85:10 92:2,6,15
stated 92:10
states 20:2 44:17
statewide 10:8
statistics 77:12
status 11:20
statute 87:3
stay 10:4 13:6,9 18:13 79:24 84:13
stayed 84:7
staying 9:9
stays 80:6 81:4
Stephens 18:23 19:14
stepped 26:25
steps 42:18 50:9
sticks 53:8
still 7:10 8:12,12 11:4,20 13:2 16:17,21,25 23:20 32:6 36:2 49:20 57:24 72:8
stool 36:16,20
stop 18:11
stopped 22:8
straightforward 46:1
stretching 24:14
strict 33:12
strictly 70:4
stringent 32:25
strips 24:20
strontium 20:6,22 21:5 22:23,24 24:11 26:3 27:22 28:4 34:16 35:17 37:20
student 36:14 80:22,23
students 15:1,6
study 23:15 38:6
stuff 20:15 47:15 64:15 79:12
sub 64:4
subject 11:4 77:4
submit 82:21
substantial 30:13 44:23
substantially 81:20
such 15:8 30:5,7 40:5
sudden 30:9 64:17
sue 71:22 72:2
sued 71:22
suffer 31:6
suggested 79:24
Suite 1:24
supervise 31:11
supervision 51:6,7
Support 7:21 8:9 12:12 12:13
supported 39:16
suppose 20:24 24:15 32:20 77:15
supposedly 25:7
sure 6:10,19 18:3 19:5 46:16,18 47:1 54:22 55:1,20 64:6 76:24 77:14 88:3
Surgeon 11:18 12:4
surprise 18:1
surveys 80:12
sweated 36:25
symmetrically 85:3
syringe 23:7
system 14:24 33:21,24 34:7,10 75:11 78:21
S-5 76:11

T

T 92:1,1
tab 7:3 26:15 39:24 41:3 41:3 42:24 44:14 57:5 72:13 76:11,18,23,25
table 12:22 47:8
tabs 76:1
tackle 64:7
take 7:6 17:19 37:9 39:8 47:18,20,21 48:1 52:13 52:13 53:18,22 55:11 63:13 70:13 78:3 79:13 82:6,11,14,22 83:13,14 83:16 87:20 89:6
taken 53:14 78:7 81:2
takes 39:20 64:2 78:4
taking 5:1 46:14 64:15 67:2 80:21 81:8 83:7
talk 13:20 72:9,9 76:19
talked 13:21 79:24 88:7
talking 26:13,14 41:15 44:21 45:21 73:2 74:5,9 77:2,18 79:1
talks 26:17
Tallahassee 8:19 10:14
Tampa 1:13,14,15,25 6:24,24 10:20 17:19 78:4
target 53:2,3
team 9:23,23
tech 34:24 36:20 43:13 44:4 47:19 48:2 52:13 52:19 55:13 60:5 62:17 86:20,24
technetium 25:25 36:2
technical 37:22
technician 73:8,8
technologies 40:12
technologist 5:8 40:4 43:14,15,25 44:1 56:4 73:1 74:3,4 75:15,25 86:17
technologists 3:11,19 24:4 42:8 56:19 61:13 69:11
technology 3:17 5:12 39:14 43:2 62:25 65:6 76:15
techs 4:8,11 20:25 47:20 47:21,22 53:13,21 74:1 88:17
tell 21:13 84:2 89:21
temporarily 27:14
temporary 54:12 82:11
tens 45:1
ten-minute 39:8
test 48:22 53:18 64:3 77:15,15 78:4,4,6,11,17 82:22 83:7 84:18,22
testing 21:22 23:24 27:6 28:16 32:14 35:1,2 43:3 83:22
tests 27:9
TGI 17:21,24
thallium 37:8,13 38:3,5,6
thallium's 37:10
than 9:5 10:24 24:11,14 24:24 28:12 32:20 34:15,17 35:21 36:24 38:3 39:17 49:5 59:20 63:17 66:23,24 77:25 78:8,15 79:3,14 88:18
thank 6:25 15:10 19:14 39:6,10 57:1,4 81:10 86:25 87:19 91:2
thanks 4:25
Thanksgiving 90:5
that 5:5,17 6:5,12,18 7:2 7:7,12,12,24 8:8,10,15 8:19,21,23 9:5,22,23 10:1,2,7,10,11,11,20 11:3,6,12,12,21,23,25 12:4,11,20 13:1,4,11,16 13:23,24 14:1,2,3,19 15:13 16:4,9,10,24 17:8 17:12,17 18:3,23 19:1 19:12,23 20:5,6,12,17 20:20,21,23,25 21:8,24 22:1,11,15,17,21 23:6 23:19,21 24:9,13,19,23 24:24 25:4,5,9 26:2,5 26:10,15,16,17 27:18 27:19,21,22 28:1,9,10 28:11,15,19,22 29:1,4,5 29:8,10,14,15,23 30:4,5 30:6,7,13 32:3,6,9,16 32:22 33:5,8,12,16,17 33:21,22 34:1,13,24 35:1,6,8,12,21,25 36:15 36:19,24 37:20 38:8,19 39:13,17,22,25 40:2,6,6 40:8,9,10,13,13,15,18 40:19 41:2,12,13,18,19 41:20,21 42:2,3,12,13 42:14 43:8,17 44:9,20 44:23,24 45:3,7,13,22 46:16,25 47:6,8,12,18 47:20,23,24 48:1,7,9,17 48:18,18,19,20,23,25 49:1,4,6,11 50:4,5,8,9 50:12 51:7,8,9,15,16,17 51:17,19 52:2,12 53:2,9 53:21 54:3,6,7,14,25 55:20 56:16 57:10,11 57:12,13 58:1 59:3,4,12 59:23 60:4,23,23,25,25 61:7,22,24 62:5,7,9,15 62:18,23 63:1,3,11 64:2 64:2,7,15,20,25 66:11 66:15,15,19 67:5,9 68:6 68:19,22 69:2,5,6,15,21 69:23,23 71:8,13,18,21 71:23 72:6,7,7,12,18 73:5,6,12,13,17,19,23 74:12,23 75:1,10,22 76:3,14,17 77:13,14,21 78:6,10,11,12,13 79:3 79:10,19,20,22,24 80:1 80:2,4,7,10,12,13,14,14 80:25 81:1,1,2,3,4,8,8,9 82:7,10,25 83:6,8,9,12 84:8,10,13 85:2,3 86:11 86:13 87:4,5,12,13,14 87:15,20,25 88:9,14 89:2,6,7,8,17 90:10,13 90:16,18,22 92:8,11
that's 6:7,9 7:21 9:9 14:12,17 16:3,9 20:17 21:21 23:17 26:5 27:20 31:8,23 32:12 33:6,8,18 33:25 34:8,12 35:10,11 37:8,23 38:15 40:1,10 41:23 42:21 44:10,10 45:25 47:2,16 48:11 49:8,14,23 50:2,14,21 52:25 54:2 59:20 60:10 61:8 63:4,24 65:12 66:11,14 69:17 70:21 71:12 72:2 74:1,11,15 78:19 79:6 80:4 82:3 83:4,6 84:4 86:10,25 88:5 90:7
the 3:1,10,18 4:13,13,13 4:18 5:11,11,13,16 6:7 6:10,16,21,24 7:3,11,12 7:13,14,15,15,16,17,20 7:22 8:2,6,8,8,10,11,11 8:16,19,22,25 9:1,3,4,8 9:15,16,19 10:4,9,11,12 10:13,14,15,15,17,17 10:19,23,24,24 11:1,4,8 11:8,14,19,19,21,25,25 12:3,4,5,6,6,8,10,11,17 12:18,22,23,24,24 13:1 13:6,7,12,12,20,21,23 14:1,4,9,17,17,19,19,19 14:23,24 15:1,1,1,3,4,6 15:7,11,19,21,22,25 16:11,19,20,25 17:1,5,5 17:9,13,19,19 18:12,16 18:19,20,22,24 19:2,6,8 19:11,16,17,19,20,22 19:23 20:2,11,12,13,14 20:15,21,25 21:1,3,4,4 21:6,8,9,10,17,17,19,24 22:1,2,2,3,4,6,6,8,12,14 22:20,23,24 23:2,4,4,5 23:15,16,17,19,21,24 24:3,4,6,7,9,10,10,15 24:19 25:4,10,10,11,11 25:17,18,18,23 26:8,10 26:12,15,18,21,21 27:2 27:3,3,6,7,7,9,10,14,18 27:20,21,21,22,23,25 28:2,6,8,16,16,20,25 29:3,3,4,6,7,8,9,9,13,14 29:15,15,16,18,18,22 29:23,23 30:1,6,11,11 30:15,22 31:2,4,7,20,21 31:22,24 32:1,3,4,5,6,7 32:8,9,10,13,13,18,21 33:1,2,3,9,10,13,18,21 33:22,22,24 34:6,8,9,9 34:10,11,12,16,17,23 34:24 35:1,2,10,12,13 35:13,13,23,24 36:1,1,4 36:9,12,16,20,23 37:1,1 37:4,5,5,13,13,14,15,16 37:19,20,23,24,25,25 38:7,12,14,14,15,16,17 39:11,12,13,15,21,22 40:2,2,8,8,8,9,11,13,13 40:14,19,20,21,23 41:3 41:3,6,8,9,10,15,18,19 41:21,21,21,22,24,24 42:2,2,6,6,9,10,15,16 42:17,19,20,22,24 43:4 43:5,5,8,10,12,14,15,17 43:18,19,20,24 44:2,3,4 44:8,12,12,13,13,16,18 44:23,25 45:1,3,4,5,6,6 45:10,12,14,14,16,16 45:24,25 46:2,2,3,3,4,6 46:7,12,12,14,16,17,19 46:20,22,23 47:2,6,8,8 47:9,14,20,21,21 48:8,9 48:12,12,15,16,19,19 48:21,21,24 49:1,2,3,10 49:13,18,19,21,22 50:2

50:2,3,5,5,10,10,11,14
50:15,23,25 51:1,9,9,10
51:10,11,11,16,18,20
51:24,24,25,25 52:3,4,6
52:8,13,13,15,16,17,19
52:25 53:2,3,3,13,14,18
53:22,23 54:2,4,4,5,9
54:15,18,19,22 55:2,5,5
55:12,13,14,16,19,21
55:25 56:3,4,6,19,21,22
56:22,23 57:3,3,6,7,11
57:12,13,13,18,21,22
57:22,22,25 58:2,11,11
58:12,13,13,15,16,19
58:20,22,22,25 59:1,2,2
59:3,4,6,8,8,10,11,14
59:16,16,19,24 60:2,3,4
60:11,12,12,18,20,22
61:5,9,13,17,18,19,19
61:20,22,23,25,25 62:3
62:4,4,6,10,10,11,11,12
62:15,15,19,21,22 63:1
63:2,3,4,4,5,7,8,11,16
64:1,3,19 65:3,4,5,11
65:16,20,21,23,23,24
65:24 66:3,4,6,10,11,13
66:13,15,17,18,19,20
66:20,20,22 67:1,1,4,4
67:11,14,17,23 68:9,12
68:14,15,19,21 69:8,11
69:14,16,23 70:2,7,9,10
70:14,16,19,20,23,25
70:25 71:2,6,7,11,12,13
71:14,15,18,18,18 72:4
72:10,10,12,13,16,18
72:19,19,20,20,24,24
73:1,3,3,3,4,5,6,9,13,14
73:16,19,22,23,24,24
73:24 74:2,19,23,25,25
75:3,3,7,14,20 76:1,2,3
76:4,8,10,11,13,18,18
76:25 77:1,3,7,11,12,13
77:16,18,20,20,22,23
78:4,6,6,7,8,11,11,12
78:13,17,17,19,19,20
78:20,21,21,25 79:1,2,7
79:9,10,11,11,13,15,20
79:25,25 80:3,5,5,6,8,9
80:11,11,12,13,14,15
80:16,16,21,24 81:2,3,4
81:4,4,4,7,8,8,12,17,18
81:22,25 82:2,3,6,9,11
82:13,17,20,22 83:7,11
83:12,13,16,17,17,17
83:18 84:5,7,8,8,12,13
84:14,15,15,17,18,20
84:20,21,22,22 85:1,4,7
85:8,8,9,10,14,18,19,19
86:18 87:2,3,6,11,12,12
87:17,20,22 88:8,10,14
88:17 89:10,12,21,23
89:23,25 90:3,4,5,9,15
90:15,17,18,21,21 91:3
92:5,6,6,9,9,10,11,15
their 9:3,24 12:13 13:9 17:11,11 20:4,4,23 21:12 24:5,25 25:6 27:11 29:2 34:15 35:6 38:18 42:1 45:14 46:11 46:23 48:23 49:3 56:16 60:13,24 66:21 67:9 68:24 75:6,21 82:13 83:22 86:21
them 6:11 14:9 22:8 23:23,25 24:5 27:11,16 29:2,4,11 30:14,17 32:3 32:8 34:14 37:9 40:7 41:9 42:19 43:10 44:10 44:19 45:1 48:25 53:7 55:4,17,19 59:13 60:8 60:15 62:2,8,21 64:2,18 66:20 67:3 69:10,10 70:17 75:21 80:24 81:17 82:12,21,25 84:2 85:1 87:24 89:20
then 6:5 8:25 9:22 11:22 12:6 14:20 16:15 17:24 21:25 22:9 24:2 25:6,20 27:23,24 30:25 31:20 33:5 34:10,21 36:7,22 41:10,12,20 42:9,13,17 42:20 44:15 45:25 46:3 46:10 53:4 54:16,20 55:14 56:13 58:16,21 63:1,19 64:1,17 66:15 68:5,6,12,16 69:1 70:20 70:25 72:20 73:2,22 76:8,16 78:18 82:23 84:3,12 87:11 88:8,10 89:9
therapist 67:22 68:1,4
therapy 3:15 14:9 39:15 60:4 65:7 66:25 67:24 68:3,8 87:10,13
there 4:16 6:16,20 8:1,8 8:18,23 10:18 11:10,12 11:12 14:18 15:16 16:1 16:5,9,10 17:2 18:11,18 19:9,17,19 20:8,15 25:1 26:13 27:5,8 28:11 29:18,19 30:1,5,10,12 30:24,25 31:20 32:14 34:6,7,21 37:12,19 39:3 41:5,13 42:10 44:7,14 44:16 45:8,15 48:3,7 53:12,18,19 55:16 57:17,22 59:1,6,17,20 59:23 60:6 61:1,15,15 61:22 64:8,9 65:10,13 65:14 67:6,9 69:20,23 69:25 71:15,17 73:1,12 75:9 77:24 78:1,10 80:8 80:9 83:23 84:10 86:12 87:16 88:11 89:3,5,9
thereabouts 7:8
therefore 46:9
Thereupon 3:1
there's 6:7 8:12 10:9,19 10:21 11:11 14:1 16:2 23:9 25:2,2 30:19 33:6 33:20 34:25 44:10,18 44:19,22 48:5,7 52:4 53:20 57:18,23 58:4,16 59:19,22 60:1,2,3 61:1 62:20 63:14 64:11 65:14 69:22,22 70:15 73:3 74:13 75:16 77:12 78:3,17,17,19 85:4 88:5 88:20 89:7
these 6:25 15:14 18:23 20:7,19,22 21:7,24 22:16 23:18 25:19 27:19 28:18,23 30:12 30:22 38:9 42:4,18 44:3 44:16 46:21 48:23 57:10,10 59:14,18 66:24 68:21 72:10 74:7 74:7 75:20 76:1,2 77:3 77:6,14 81:24 84:8
they 4:14 9:2 11:19 12:13 12:19,24 13:6,7,9 15:6 15:7 19:16,16,19,21 20:3,5,6,7,20 21:10,17 21:22,23,25 22:3,5,7,7 22:8,9,16 23:22,24 24:2 24:5,6 25:6,7,9,12,19 26:8,9,11,17 27:12,13 27:22 28:10,12,16 29:5 29:7,8,13,14,25 30:13 30:17,19,20 31:1,11,14 31:16,18,24 32:8,9,9,9 32:11,15,17,18,19 33:5 33:6,8,8,13,16 34:4,10 34:19,20,21,22,22 35:5 35:10,23 37:9,17 38:3 43:11 46:10,12,22 48:17,19,22 49:15 50:17,19 51:3,3,4 52:6 52:8 54:6,16 57:8,9,9 57:20,24 59:6 60:25 61:9 62:2 63:22 64:3,12 65:8,15 66:18 67:5,15 68:12,16,25 71:22,22 74:8 75:15 76:9,12,12 76:12 77:4,7,14,20 78:13,22 79:6,24 80:3 80:15,15,18,18 81:12 81:13 82:9,10,14,16,17 82:22 83:8,11,11,13,14 83:16,21 84:1,4,12,17 84:24,25 85:5,5 86:13 86:22 87:17 89:3,8 90:22
they'd 37:16 38:3
they'll 18:3 25:20 54:16 82:11 83:2 84:3
they're 8:12 11:21 15:17 16:5,11 21:1,21 33:7,11 45:2 47:18 48:2 52:16 53:2 56:20 57:16,17 58:18 60:18 64:10,15 64:17,19 67:8,15 68:15 68:16 69:6,9 70:9 72:6 75:19 77:11,15,19 81:15,16 83:7,20 84:3
they've 25:13 31:2 33:17 46:1 58:1 59:5 64:2 66:21 68:23 80:13 81:5 82:12
thing 13:20 14:13 16:6 24:6 25:4 34:12 36:2,24 38:13 40:8 41:24 42:6 45:10 47:19 49:23,24 52:16 53:10 60:12,17 65:3 68:11 72:24 73:3 76:9 84:12 85:3 87:22
things 11:9 13:25 14:2 15:24 17:19 25:19 26:10,11 41:2,13,14 52:4,18 62:10 68:21 73:6 77:6
think 3:4 4:12,14,23 5:22 9:5 10:12 12:25 13:8 14:10 19:1,3 22:17,20 24:6 25:18 26:1,4,7,12 27:21 28:3 30:3,6,10,12 33:17 35:11 38:12 39:16 40:8 41:2,5 45:16 47:2,19,23 48:11,14,17 50:4,6 51:17 52:16 53:12,15,16 54:2,3,16 56:16 60:20 61:13 64:7 64:20 65:25 66:8,14 67:9,13,17 69:8 70:7 76:2 77:3 78:22 85:13 87:4 88:1,11,13,16 90:8
thinking 52:10,12 79:5
third 43:15 48:7
this 3:3 4:23 5:15 6:3,8,9 6:11 7:9 8:10,14 9:12 9:24 10:16 11:14 13:15 15:5 18:18 19:2,14,22 20:10,12,13 21:7,25 22:12,14,21 23:1,2,2 25:24 26:16,16,25 27:17 28:19 29:6 31:2,9 32:2,24 36:25 37:4,25 39:4,10,12,18,21 40:1,2 40:4,10 41:4,7 43:18 44:4,19 45:20,21 46:7,9 47:1,3,6,23 48:15 49:8 50:7,13 51:21 52:22,23 53:9 57:6,20 61:20,21 62:13 63:2,5 64:7,11 65:4,17 66:1,2,5 68:17 69:21,21 72:14,17,17 72:18,21,25 73:7,22,25 75:13,20 78:1 79:6,12 79:13,18,21 80:18,22 80:24 81:6 82:3 83:24 84:1,6,11,20,20 86:15 87:3,5,11,23,25 88:8,8 92:16
thorough 19:3
those 11:7 13:17,18 14:5 14:11,12 28:8 29:20 31:6,10 33:7,18 34:5 38:16 40:7 42:9 43:8,16 44:25 54:1,7 58:4,5,7 59:3,24,25 60:1,19,25 61:3 64:4 67:3 70:20,24 73:19 75:8 76:13 79:4 89:14 90:21
though 18:10 22:5 36:12 61:12 78:15 79:15 81:3
thought 22:13 36:18 63:4 65:25 66:1 74:11
thoughts 32:4 76:19
thousands 59:13
three 14:25 24:13 26:15 27:3,7 33:19 41:14 43:4 43:11,16 44:22 58:4,5,7 58:11,12 60:1,8,18 61:3 65:23 73:21 88:17 90:21
threshold 37:24
through 10:10,24 20:4 21:6 25:12 30:14 36:4,5 36:11 37:14 42:17 43:17 46:16 64:3,24 66:2 76:5 80:19 81:1,2 90:15
thrown 85:2
thyroid 54:17
ties 61:1
Tim 3:16
time 5:1 8:6 14:17 15:19 19:6,12 22:15,21 24:10 25:16,17 26:20 27:21 38:16 69:18,25 70:5 72:4 76:5 77:24 78:3 88:16
timeframe 22:14
timeline 41:11,24 42:6,17
times 15:12 17:3 28:2 87:4
Timothy 2:6
Tineo 2:7 4:5,5,19 31:10 33:4 47:24 50:14 51:3,6 53:11,16,20,23 54:1,11 54:21,24 55:3,6 63:10 63:21 64:22 67:13 68:12 69:8,20 70:9,12 70:18 73:10,15 85:23 86:8 90:5,25
tiny 66:4
title 45:25
titles 41:18,21 57:11 76:14
to 3:3 4:18,23,25 5:14,15 5:16,17,22,22,24 6:5,6 6:8,9,10,11,12,17,18,18 6:24,24,25 7:3,6,19,19 7:20,25 8:12,14,16,17 8:24 9:2,19,19,20,22

10:3,4,7,22 11:6,6,11 11:21 12:5,14,14,25 13:7,9,14,16,20,23 14:2 14:21,23 15:2,3,7,7,8 15:13 16:5,9,23 17:4,5 17:8,8,9,9,10,11,13,13 17:15,18,18,20,21,25 18:7,13,16,16,20,20 19:11,14,20,20 20:10 20:11,13,14,15,19,24 21:1,2,12,16,22,23,25 22:10,11,15,20,20 23:2 23:4,6,13,14,16,17,23 24:11,15,18,19,25 25:6 25:17,22 26:1,3,6,16,22 27:14,16,16,23 28:3,19 28:21,22,25 29:1,2,4,7 29:8,10,14,23,25 30:8,9 30:9,11,20 31:2,6,11,14 31:25 32:1,5,6,6,10,10 32:20 33:3,8,9,14,22 34:5 35:6,7,9,10,17 36:9,10,12 37:2,5,6,9 37:19,22,23 38:10,12 38:14,15,21 39:8,12,13 39:18,23 40:3,5,11,19 40:20,20,23 41:5,11,14 41:17 42:2,4,4,7,8,22 42:24 43:7,10 44:8,11 44:11 45:22,22,25 46:3 46:4,5,11,15,21,23 47:1 47:4,4,7,7,19,23,24 48:6,8,9,11,24 49:1,5 49:13,14 50:2,2,7,14,21 51:10,11,18,20,21 52:3 52:3,11,13,16,17 53:2,4 53:5,6,10,16,18,18,18 53:21,22,23 54:7,21,22 55:2,7,12,13,14,19 56:2 56:8,12,15,19,20,25 57:2,4,5,6,10,18,19,20 57:20 58:6,10,24,24 59:16 60:11,15,15,20 60:24,25 61:9,10,18,19 61:20,25 62:2,2,3,4,6,7 62:9,10,10,12,13,13,13 62:17 63:2,2,5,11,12,13 63:13,13,14,14,15,15 63:18,19 64:6,8,10,23 64:24,25 65:1,3,12,16 65:17,25 66:2,6,8,15,18 66:20,21 67:1,9,14,17 67:23,24 68:2,5,12,15 68:17,17,18 69:3,4,6,8 69:9,10,11,17,19 70:1,2 70:10,10 71:10,14,16 71:17,18 72:8,9,9,11,12 72:14,18,21 73:15,16 74:1,12,23 75:11 76:8 76:18,19,20,20,23 77:11,14,15,16,16,18 77:22,23 78:5,12,25 79:2,3,5,8,12,13,14,16 79:16,18,22,23,24 81:2 81:5,7,9,15,16,17,19,20 81:21 82:14,16,17,18 82:19,21,21,23 83:13 83:14,21 84:1,2,3,5,6 84:12,20,21 85:4,16,18 86:13,15,20,25 87:5,12 87:14,21,22,24 88:7,21 89:3,13,13,19,20 90:7 90:20,24,25 92:8

today 53:17 78:4 79:18
today's 42:7
together 7:1 9:20 18:24 19:15 53:2 59:25 72:11
told 43:19
tomography 43:15 44:1 45:13
tomorrow 11:18 78:5
ton 22:11
tonight 56:8
too 6:20 9:16,18 24:7,21 25:9 26:9 35:10 37:21 54:24 61:1 63:24 73:17 74:14 75:8 87:3 88:23
took 19:20,23 37:16 41:8 77:9 78:7 80:8 87:17
top 9:24 11:19,21 57:13 57:22 59:2,8 63:4 74:2
topic 15:18 19:21 39:11
total 35:13 60:4
towards 56:20
traced 20:7
tracing 20:19
track 32:2
tracked 75:12
Traditionally 89:15
trained 34:24 64:16
training 29:12,13 32:8,9
transcription 92:12
transfer 75:4
transferred 7:19
transparent 8:16
travel 5:23 6:1
treatment 37:5
tremendous 30:11
tremendously 38:11
tried 13:9
trouble 44:12 55:4
true 31:8 32:18 92:11
truly 32:22 88:19
truthfully 64:18
try 17:5 19:20 25:22 40:17,20 51:21 53:1,18 55:23
trying 9:2 20:10 21:1 23:14 26:22 28:22 50:7 62:2 69:8,9
tsunami 25:10
Tuesday 90:17
Turkey 37:11
turn 4:23 6:6,9 7:3,15 15:25 18:20
tweaking 8:13
twice 26:1 28:1 38:9 82:14
two 17:21 34:22 41:5,13 43:1,8,17,25 48:16 54:7 57:13 58:16 59:8,25 66:24 67:10 71:17 74:10,13 81:16 87:4 88:17 89:14,22
two-step 71:16
type 33:15 45:12 50:22 64:17
types 5:16,18 42:5,8,25 43:12 44:22 63:23 71:14 72:23 73:6
typical 38:7

U

Uh-huh 12:1
ultrasound 62:4 64:16,18
ultrasounds 64:9,12
umbrella 7:12
unanimous 86:9
Uncle 39:5
under 7:11 37:25 38:1,2 39:19 51:6 61:5 67:25
underneath 6:2 39:24 76:4,10
understand 7:16 23:12 24:8 68:14
understanding 32:24 86:23
unit 4:8 35:16
United 20:2
units 35:14
University 3:9,14
unless 48:1,10 68:4 75:20 85:16
until 13:16 34:11,22 52:22 53:6 66:4
up 5:15 11:19,21 12:17 12:18,19,20 15:24 16:25 20:3,6,12 22:19 23:2 25:12 26:16 27:15 28:6 40:3,19 44:6 45:10 47:9 48:24 53:3 55:10 59:21,21 60:3 74:2 76:21 80:4 82:4 83:24 85:6 86:14,15
update 13:13 19:4,6 77:1
updated 17:12 18:22
updates 29:3,9
upon 25:20 45:7 78:25 82:25
upper 72:18,20
urgent 16:4
urinated 36:25
us 3:4 5:2,17 8:20 9:2,8 13:10 17:20 18:1 21:13 22:10 23:17 27:1 28:15 28:19 34:20 37:12,16 39:23 40:5,11 46:4 56:24 57:6 62:12 65:16 69:19 71:18 73:6 79:22 82:12,18 84:3
usage 26:5
use 12:14 15:2 21:2 22:16 22:17 24:15,17,19 25:13 26:7 28:23 29:6 29:14 30:12,17 31:24 32:10 34:4 40:12 46:24 50:7 53:10 81:19 83:17 83:21 88:21 90:7
used 21:21,23 22:9 23:22 24:22 25:5 32:2,15 59:5 62:5 67:9 73:5 81:25 89:3
uses 42:3 78:12
using 20:21 22:8,8,12 24:5 27:9 36:15 38:14 64:1 76:14 84:9,13
usual 24:24
usually 83:13,17 90:8

V

vagueness 52:6
values 26:19
vascular 58:17 60:23 61:4 63:8 76:14
vascular-interventional 58:3
vast 10:12 61:13
vendor 83:20
verification 13:22 14:3 73:25 75:14
version 40:9,10
versions 39:22
vertical 59:8
very 8:15 19:12 21:2,3,4 27:9 35:21 47:9 48:19 49:21 56:19 58:15 60:2 75:18 77:11 83:9,9 86:19 89:12
vetting 77:14
VI 58:1,5,7 76:6
vicinity 79:10
Victor 12:9
view 53:1
Villages 16:19,20 18:17
violation 28:18 29:19 30:2
visit 21:25 22:1
visiting 37:11
volume 24:7 32:5
vote 85:22
VRA 51:2

W

wait 52:22
waiting 12:4 15:12 53:17
wall 72:19
wallet 18:13 58:1 72:19 72:20 73:3,4
wallets 75:7
wallet's 18:9
want 4:25 9:20,20 17:25 21:12 25:17 28:21 29:25 37:2 38:10,12,14 39:8 41:17 44:11 47:1 48:6,9 51:24,24 52:8 56:12 58:24 62:17 63:18 64:6 66:2 67:17 68:16,17 69:19 74:25 75:3 76:20 84:5 86:13 86:19,25
wanted 6:12,25 13:14,16 14:23 18:20 29:1 39:23 40:15 56:15 61:19 62:10 72:21 86:20 89:7
wanting 65:15
wants 5:22 18:16 63:2 70:9 85:16 89:20
warnings 29:5
Warren 2:6 3:23
was 5:14 9:16,22,24 13:1 18:18,25 19:1,4,5,17,22 20:6,8 21:5,5,6,7 22:17 23:22 25:4 26:10 27:4,8 27:18,22,22 28:2,3,9,19 28:21,25 30:1,5,7,10,12 30:18,21,24 31:2,4,12 32:3,22 33:10,20 34:15 34:16,20,23 35:25 36:1 36:7,16,20,21,23,23 37:1,11,12,14,15,18 38:8,20 39:9 40:2,8,13 40:13,17 41:25 44:6 46:4 47:24 48:12,16,17 48:20 49:4,6 50:23 51:7 51:8,10,16,17,17,18 56:2 61:22 65:5 66:20 67:4,6,10 68:19 72:4,7 72:7 78:14,16,22 80:7 80:12,12,21,22 81:1,2 84:10,13 88:11,11,17 92:8
wasn't 23:21 34:16 36:16 37:23 38:13,19 50:5 66:19
watch 57:3
water 8:5 24:19
way 6:12 9:3,4 12:8 13:11 16:2 18:12 24:6,23 25:19 26:15 27:23 36:23 38:1,1,2 39:7 45:16,21 46:4 49:14 50:2 55:17 59:16,21 61:19 62:21 64:11 65:4 67:2,19 74:19 79:5,7,9 84:1 85:14 88:8
ways 67:10 81:16
we 3:4,5 5:3,17,20,20 7:5 7:6,9,10,16,18,19,21,22 7:23 8:13,16,18,21,21 8:23,24,25 9:3,6,9,18 9:19,20 10:7 11:4,12,17 12:3,8,11,14,16,20 13:14,16,17,18,20,21 13:24,24 14:14,21 15:13,17,18,22,23

16:14 17:3,4,5,5,15,17 17:17,18,23 18:6,11 19:3,8,24 20:12 21:21 22:11,13,21,21 24:12 26:13,20,22,23 27:2,7,8 27:11,14,15,17,21,23 28:1,4,9,12,15,16,19,22 29:1,12,15,16,21 30:7 31:25 36:6,14,18 39:5,7 39:18 40:4,6,14,18,19 40:19 41:7,13 42:2,10 42:20,24 43:1,5,8,10 44:5,7,11,17,21 45:3,3 45:4,7,22 46:3,5,6,14 46:15,18 47:2,8,23 48:21,22 49:20 50:9,10 50:12 51:13,15,15,24 51:24 52:14 53:4 54:21 54:22 56:12,13,14,24 57:5,7,13 58:6,22 59:9 59:10,20,21 61:18,19 61:22,25 62:2,9,9,12,14 62:15,17,18 63:2 64:23 65:22,25 66:1,2,3,6,8 66:14 68:5 69:12 70:13 70:19,20,25,25 71:1,3 71:13,14,20 72:10,15 72:18 73:13,14,23 74:8 74:9,12,15,16,22,23 77:24 78:24 79:23,24 80:7,8,11,20 81:1,17 82:12,19 83:9,12 84:7,8 84:18 85:13,19,21 87:13 88:3,25 89:10,13 89:17,18 90:8

website 44:3,9 46:8,12 82:22 85:9

week 15:7,24 18:25,25 19:1 27:15 37:14 89:23 90:5,7,10

weeks 24:14 34:22 89:22

welcome 6:23 57:2

well 6:23 12:13 18:8 19:18 20:9 23:23 28:6 28:15 33:24 34:6 36:18 39:10 48:22 52:14 55:16 57:1 60:6 62:20 64:13 65:1,3 67:3,16,21 70:16,18 72:2,8 73:17 75:6 76:1 79:22 81:13 82:1,7,9 85:5 90:14 91:2

went 12:19,25 13:7 25:12 27:23 28:6,16 48:21 68:4

were 4:14 9:10 13:20 14:12 19:19 20:6,20,21 21:7,8,11,17,23,25 22:2 22:5,6,12,16 23:21,22 23:24 24:1,2,5,6,21,21 24:23,24 25:5,7 26:11 26:13,21,22 27:10,13 27:13,19,19 28:1,18 29:11 30:22,23 31:1,12 31:16,19 32:14,15,18 38:18 39:3,18 45:8 48:19 49:1 59:4 61:3 62:2,2,3,9 67:5,25 71:21 75:2 80:7,9,13,14 80:14,15

weren't 19:6

Wesley 92:15

we'll 6:13 34:2 44:24 51:25 54:7 55:19,23 56:13 72:6,10,11 75:9 90:20

we're 5:16 7:7,13,13,25 8:5,6,14 10:11,12 14:16 15:11,12,15 16:7,13,18 17:9,18 18:6,19 26:15 30:9 32:19,20 41:23 45:20,21 46:18 51:8 52:14,15 55:22,23 56:17 66:17 67:14,16 67:17 68:18,21 69:4,23 70:1 71:16 72:5 74:5 79:18,23 82:23 84:19 90:8,16,24

we've 11:20 13:17 39:11 41:25 44:2 47:5,5 58:9 72:22 74:10 81:25 89:15

what 6:4 7:16 10:1,8 11:10 15:21 16:10,23 17:13 20:1,18 21:1,5,20 22:21 23:15,16 25:13 25:22,23 26:13,17 27:1 28:15 29:11 31:11 33:8 33:18,21 34:4 36:22 37:3 38:7,24 39:21 40:4 40:21 42:1,7 44:6 45:25 46:5,20,24 48:12,17 49:12 51:3,4,6,7,18,20 52:1,14 53:3 57:8 59:8 61:9 63:11 64:10,19 65:18 66:21 67:8,8,15 67:21 69:3,4,19 70:21 70:22 71:19 73:23,25 76:21,21 77:15,19 79:22 80:11,11,15,20 80:24 81:1,7 84:4,6,15 85:10 86:17,25 90:15 90:16,22

whatever 11:10 38:16 42:14 46:24 55:23 68:16 78:13

what's 7:15 18:10 22:23 26:4 52:3 55:8 65:10,22 80:24

when 6:19 7:6 15:5,6 25:1 26:20,25 27:21 29:15 32:12 34:1 36:1,21 42:21 44:20,20,21 45:3 50:10 51:15,15 56:12 57:19 66:14 67:21 68:21 80:19 83:16 88:7 90:2

where 7:7 9:13 12:17 14:19 16:1 17:18,25 21:21 27:3 29:13 31:1 38:17 41:6,7,23 42:15 48:22 59:2 63:24 65:24 70:24 71:13 73:1 75:14 75:14,24 76:6 81:17 83:24

whereas 49:22 80:5

wherefores 80:5

WHEREOF 92:14

whether 62:14

which 7:11 8:15 9:3 12:22 13:21 17:22 18:25 21:1 21:11 23:24 27:12 30:22 34:2 36:3 38:6 39:20 41:15,16 42:8,15 57:9,16 58:2,8,18 61:3 62:16 64:12,18 68:24 72:17 74:19 78:14,25 79:25 81:21 84:13,19 86:17,21

whichever 18:2 70:18 72:9

while 37:16 55:11 77:1,8

Whitten 2:12 4:9,9 10:3 14:13,16 15:11 69:22 70:11,21

who 9:12 10:22 11:9,24 12:5,6 14:11 17:23 23:17 31:5,6,24 37:8 43:3,4 46:17 47:22 52:5 53:13,13 54:18,19,20 57:24 61:25 62:6 63:5 64:9,16 79:20 86:21 88:5,11 89:18

whoever 46:8

whole 8:14 9:9 28:7,9,16 30:15 31:23,23 49:23 49:23 53:13 66:19 87:12

who's 41:12 48:10

why 3:3,4 18:1 37:8 44:10 45:20,20 56:13 57:16 62:20 66:5 69:11,13 70:15 72:17 83:8 90:8

will 7:3,5,9,16,18,22,22 8:7,15,18 11:12 12:15 14:3 15:16 17:12,12 24:19 26:15 27:1 33:12 34:1 41:18 42:12 46:1 48:23,24 54:3 55:11 73:17 74:3 75:7,8,9,22 75:25 77:1,7 79:2 83:24 84:2 89:6,25

William 2:4

wings 16:18,25

with 3:5,8,13,21 4:7 5:2 6:9 7:13,14 8:8,19 9:15 9:23 11:13 12:19 13:10 13:25 14:1,23 15:11,15 17:20 18:22 21:20 22:12,12 23:15,17 26:6 26:18 27:2,15 28:20 29:13,20 30:1,5,24 32:3 33:4,25 34:18 36:17 37:2,9 39:5 41:22,25 42:8 43:1,22,24 44:24 45:11 46:12 47:9 48:18 48:19 50:12 51:18 52:22 53:5,6,9,17 54:7 54:7,21 55:5,23 56:17 58:1 59:21,23,24 62:22 63:10 64:4,22 66:23 68:9,11 69:20 70:23 71:21 81:6 82:12,22 83:21 84:1,7,13 87:13 87:14 90:9,13,21

within 16:16 34:6

without 24:7 62:15 68:10

WITNESS 92:14

wondered 29:25 37:3

wondering 33:20

won't 44:8 45:9 61:24 87:11

word 58:19

work 5:2 7:4 10:13 11:12 15:7 25:19 48:18,20 49:2,2 52:5 54:3 56:20 87:21

worked 9:24 36:15

working 9:3 10:24 13:24 14:21 15:11 36:17 52:14,15 56:17 69:23

works 10:10 79:4

worksheet 6:7

workshop 42:12,20

world 57:6

worry 18:8

worth 33:11 39:3

would 16:7 19:12 29:24 30:4,7,8 33:18,21 35:19 37:6 38:3,7 39:13,21 40:10 41:2 42:2 47:12 49:17 50:4 60:19,19 62:12,20,21 70:21 73:25,25 74:22,22 75:14,15 79:10 82:7 83:8 84:7,7 85:18 86:23 87:21,25,25 89:19,20

wouldn't 25:12 30:3 67:16,17 75:3 83:25

Wow 26:13

wrapped 79:12

write 10:14 33:14 45:22 63:5

written 46:4 65:5

wrong 84:25

X

x-ray 14:7,10 16:4 40:24 47:20 72:15 75:16,25 88:17

Y

yeah 9:14 12:12 13:3,3,8 14:15 16:23 17:10 23:8 24:9,23 25:15 26:10 30:3,16 31:5,18,22 33:11 35:3 38:19 43:24 47:24 49:17 50:4,19 51:1,5,12,25 52:12,24 53:8,25 54:21 55:11,13 61:8 62:24 65:3 67:12 67:25 71:12,12 72:2,5,5 73:17,21 74:15,22 75:24 81:15,25 82:5 83:4,8,19 85:12,23 87:2 88:18 89:2 90:9,19

year 13:15,21 14:25 38:9 39:4,18,21 45:6,7 47:3 77:19 78:25 79:3,14,20 88:7,8 89:6

years 9:18 25:14,25 36:6 36:15 37:12 39:12,16 39:17 48:16,16 50:13 62:11 71:21 77:7 80:17 80:19 82:21 84:8 85:20 87:24

year's 39:3

yellow 59:2

yes 4:15 5:6 10:6 12:24 19:10 24:5 33:1 45:18 56:5 60:8 83:20 87:19

yesterday 18:12

yet 8:21 30:20 86:19 88:22

you 3:3 5:5,24 6:2,3,4,4,5 6:8,9,10,11,12,17,19,19 7:3,3,7,8,9,13,15 8:7 9:17 10:2,8 12:18,22 13:3,14,16,22 15:6,8,8 15:10 16:5,19,21 17:25 18:1,7,7 19:11,14,22,23 20:18,25 21:12 23:6,20 24:10,13,17,18 25:1,18 25:25 26:1,3,4,5,14,15 27:1 28:11 29:1,19 31:20 32:1,12,15,23 33:16,18 35:6,7,8 36:2 36:3,9,10,24 37:17 38:5 38:10,12,13 39:6,7,10 39:22 40:9,15,16,23 41:2,10,17,24 42:14,14 42:15,17,21 43:11 44:8 44:12,15,15,17,20,20 45:9,13,19 46:24,24 47:19 48:6,24 49:2,12 49:18 50:6 51:13 52:18 53:4,7 54:12,18 55:7,9 56:15,15 57:1,4,25 58:24 59:2,2,4,7,11,11 59:15,15,16,18,22,25 59:25 60:2,3,6,10,15,19 60:21,22 61:2,17 62:3 62:11,16,17,19,20,24 63:4,10,15,18,18,19 64:6,6,10,22 65:1,5,13

65:13,15,18,24 66:5,15 67:11,25 68:1,3,4,5,6,9 68:13,25 69:1,2,3,24 70:22 71:23 72:1,12,13 72:20,21,21 73:1,2,6,18 73:19 74:5,17,18,19,25 75:1,3,4 76:3,5,5,8,18 77:5 78:18 79:2,3,13,14 79:16,18,19,22 80:19 81:10 82:7,18,19 83:17 84:1,14,15 85:4,9 86:18 86:19,25 87:5,11,19,20 88:9 89:21 90:2,2 91:2
your 5:1 6:2,2,7,13,19 26:14 27:17 36:3 39:24 39:24 61:11 68:13 71:9 76:4,19 83:22
You'd 79:8
you'll 7:21 8:10 41:3,6 44:20 57:10,12 58:25 76:11 80:1,2
you're 6:9 15:22 24:11,15 26:1,3 35:1,2,9 41:15 57:2,19 66:24,25,25 67:1,22,22,23 68:1 79:1 81:18,19 82:21
you've 9:17,18 65:23 67:22

Z

zero 22:4 25:1,2 29:8
zeroes 22:5 26:9 28:18 29:17,23 32:12 33:4
zeros 22:2
Z-Score 85:2

$

$40 73:16
$45 70:2,10

0

02 35:13,19

1

1 7:8 44:14
1st 13:16 39:20 42:10 46:15 90:15
1,508 13:18
1,619 13:17
1.7 14:14,15
1.78 14:21 15:13
1:16 65:21
1:56 91:3
10 36:14
100 16:15
11:41 65:20
12 15:22 28:2,11,13
12th 90:3
123 27:15,16,17 28:1
14th 90:4
15 13:16 36:14 80:9
15th 41:25
16th 90:18
17th 27:20,23
18 22:4,6
1980 82:1
1980's 78:22

2

2 35:19,19 79:9
2nd 90:17
20 28:5 30:20
200 77:4 79:4
2001 87:13
2005 51:14
2011 22:15
2012 1:9 92:16
2012-168 40:1
2013 16:23,24 42:21
21 21:23 22:2 26:21
21st 89:23
21,700 59:17
22 1:9 25:13
22nd 27:20,24
229-8225 1:25
25 22:17
27th 90:1
28 22:17

3

3 45:13 79:5
3,000 59:13
3,600 59:22,23
30 21:24
30th 8:24 92:16
309 39:19,20 40:3
33602 1:25
33607 1:15
35,000 22:13
37 45:15
376 39:19
379 20:9

4

4 89:2
4.9 28:13,13
429 28:9
45 70:7
468.302(3)D 87:5
47 88:10
48 44:19 45:16 88:10
482 14:12

5

5 22:6 37:24
50 28:4 59:19
500 89:2
501 1:24

6

6 28:5 88:10
600 45:5,6
64 22:24
640 59:21
682 44:18

7

7.5 85:6
700 88:10
710 45:15
73 79:9
74 79:21 84:24
75 16:7 21:2 22:25 77:23 78:14,17,20,25,25 79:3 79:25 84:13 85:6,19
775 1:24
78 79:8

8

8th 90:15
813 1:25
82 17:16

9

9 22:2
9th 90:17
9,808 13:18
9:00 1:10
90 16:15
99 36:20