events. The licensee responded on October 8 and 12, 1998, listing adequate actions to prevent recurrence of similar events.

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Agreement State Licensees

AS 98–1 Medical Brachytherapy Misadministration at Tuomey Regional Medical Center in Sumter, SC

One of the AO criteria notes that any unintended radiation exposure to an adult (any individual 18 years of age or older) resulting in an annual total effective dose equivalent (TEDE) of 250 millisievert (mSv) (25 rem) or more; or an annual sum of the deep dose equivalent and committed dose equivalent to any individual organ or tissue other than the lens of the eye, bone marrow, and the gonads of 2500 mSv (250 rem) or more will be considered for reporting as an AO.

Date and Place—September 23, 1997; Tuomey Regional Medical Center; Sumter, South Carolina.

Nature and Probable Consequences—On September 23, 1997, a patient was scheduled by a referring physician (urologist) for a palladium-103 (Pd-103) permanent prostate seed implant via transrectal ultrasound guidance. However, the referring physician had two patients with identical names and the wrong individual got the orders for the Pd-103 treatment. The patient was identified at the Medical Center by verbal means (asking the patient's name) and by checking the name on the patient's wristband. In addition, the patient had signed a consent in the chart stating he was at the hospital for seed implant for treatment of prostate cancer. The patient received 67 seeds of Pd-103 at 37 megabecquerel (MBq) (1 millicurie (mCi)) per seed, thus a total implant activity of 2479 MBq (67 mCi). On the basis of pre-implant dosimetry, the periphery of the prostate was to receive a maximum dose of 9000 centigray (cGy) (9000 rad). The posterior wall of the bladder and anterior wall of the rectum would receive approximately 4000 cGy (4000 rad) and the whole-body dose would be less than 1 cGy (1 rad). The procedure was performed without complication.

On September 25, 1997, the referring physician notified Tuomey Regional Medical Center that he had two patients with identical names and that the wrong individual had received the implant. On September 29, 1997, the authorized user met with the individual who had received the Pd-103 treatment and discussed the potential early and late side effects, and all necessary precautions.

The licensee stated that the early consequences from this type of implant usually are dysuria and possible hematuria, which, if they occur, resolve in several days. Late consequences could be an approximately 25 percent chance of impotence. Damage to the bladder and rectum occurs in fewer than 1 percent of patients.

Cause or Causes—The referring physician had two patients with identical names. The wrong individual arrived at Tuomey Regional Medical Center with orders from the referring physician for the Pd-103 seed implant. The patient who should have had these orders had been to Tuomey Regional Medical Center for a pre-operative interview. When the wrong individual presented for treatment at Tuomey Regional Medical Center with orders for the Pd-103 seed implant, the registration process failed to note that he was not the same individual who had undergone the pre-operative interview.

Actions Taken To Prevent Recurrence

Licensee—The licensee performed a comprehensive review of the patient identification process once the incident occurred. As a result, the patient identification system was revised on a hospital-wide basis in order to prevent recurrence of this type of event.

State Agency—The State agency investigated the event and a Notice of Violation and Enforcement Conference was held on February 10, 1998. A Notice of Noncompliance was issued for failure to meet the objective that each administration is done in accordance with a written directive. The licensee responded in writing and no additional actions were required.

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Dated at Rockville, Maryland this 2nd day of June, 1999.

For the Nuclear Regulatory Commission.

Annette L. Vietti-Cook,

Secretary of the Commission.

[FR Doc. 99–14468 Filed 6–7–99; 8:45 am]

BILLING CODE 7590–01–P

RAILROAD RETIREMENT BOARD

Actuarial Advisory Committee With Respect to the Railroad Retirement Account; Notice of Public Meeting

Notice is hereby given in accordance with Public Law 92–463 that the Actuarial Advisory Committee will hold a meeting on June 15, 1999, at 10:30 a.m. at the office of the Chief Actuary of the U.S. Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois, on the conduct of the 21st Actuarial Valuation of the Railroad Retirement System. The agenda for this meeting will include a discussion of the assumptions to be used in the 21st Actuarial Valuation. A report containing recommended assumptions and the experience on which the recommendations are based will have been sent by the Chief Actuary to the Committee before the meeting.

The meeting will be open to the public. Persons wishing to submit written statements or make oral presentations should address their communications or notices to the RRB Actuarial Advisory Committee, c/o Chief Actuary, U.S. Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611–2092.

Dated: May 26, 1999.

Beatrice Ezerski,

Secretary to the Board.

[FR Doc. 99–14323 Filed 6–7–99; 8:45 am]

BILLING CODE 7905–01–M

SECURITIES AND EXCHANGE COMMISSION

Proposed Collection; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of Filings and Information Services, Washington, DC 20549

Form F–6, SEC File No. 270–270, OMB Control No. 3235–0292

Regulation S–T, SEC File No. 270–375, OMB Control No. 3235–0424

Notice is hereby given that, pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.), the Securities and Exchange Commission (''Commission'') is soliciting comments on the collection of information summarized below. The Commission plans to submit these existing collections of information to the Office of Management and Budget for extension and approval.

The Commission under Section 19 of the Securities Act of 1933 established Form F–6 for registration of American Depositary Receipts (ADRs) of foreign companies. Form F–6 requires disclosure of information regarding the terms of the depository bank, fees charged, and a description of the ADRs. No special information regarding the foreign company is required to be prepared or disclosed, although the foreign company must be one which periodically furnishes information to the Commission. Such information is available to the public for inspection. The information is needed to ensure that investors in ADRs have full