

COUNTY OF SAN DIEGO



**Department of Environmental Health
Community Health Division
Radiological Health Program**
9325 Hazard Way, San Diego, CA 92123
Tel (858)694-3621 Fax (858)694-3629

KIVA #: _____

PLAN CHECK #: _____

ACTIVITY #: _____

FEE AMOUNT \$: _____

PAYMENT TYPE:

CASH CHECK _____
Check Number

RADIATION SHIELDING PLAN CHECK APPLICATION

Plans submitted by: _____ Phone #: () _____

Facility Name/ Owner's Name: _____ Phone #: () _____

Job Site Address: _____ Zip: _____

Mailing Address, if different: _____ Zip: _____

X-RAY MACHINE INFORMATION

# of Rooms	Manufacturer	Model/Type
_____	_____	_____
_____	_____	_____

OWNER/REPRESENTATIVE DECLARATION: I understand that the fee paid is based on my declaration of the radiation shielding classification. If the declaration is incorrect, I understand that this application will not be approved until the appropriate fee is paid.

Signature: _____ Title: _____ Date: ____ / ____ / ____

This space for Office Use Only:

CLASSIFICATION	NO. OF ROOMS	FEES FY 08-09 (\$)	TOTAL
DENTAL, MEDICAL, or INDUSTRIAL	FIRST TWO ROOMS (6CRAD----O)	82.00	
	EACH ADDT'L ROOM UP TO 6 (6CRAD----O)	44.00 EACH	
	MORE THAN 6 ROOMS (6CRADHR--O)	IN ADDITION TO \$258 BASE FEE, HOURLY FEE BASED ON REVIEW TIME	