

# 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 '09-10 (\$)	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	