COUNTY OF SAN DIEGO

Department of Environmental Health
Community Health Division
Radiological Health Program
5500 Overland Ave Ste 110, San Diego, CA 92123
Tel (858)694-3621 Fax (858)694-3629

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 '20-21($)	TOTAL
DENTAL, MEDICAL, or INDUSTRIAL	FIRST TWO ROOMS (6CRAD-----O)		114.00	
	EACH ADDT'L ROOM UP TO 6 (6CRAD----O)		52.00 EACH	
	MORE THAN 6 ROOMS (6CRADHR--O)		IN ADDITION TO $326 BASE FEE, HOURLY FEE BASED ON REVIEW TIME	