COUNTY OF SAN DIEGO

Department of Environmental Health and Quality
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		FEES FY '21-22($)	TOTAL
DENTAL, MEDICAL, or INDUSTRIAL	PLAN CHECK BASE FEE	94.00	
	IN ADDITION TO BASE FEE, HOURLY RATE OF $153 PER HOUR BASED ON REVIEW TIME.	153 X ____ HOURS	