PLAN CHECK NO:_____

FEE AMOUNT $: _____

DEPARTMENT OF ENVIRONMENTAL HEALTH AND QUALITY
COMMUNITY HEALTH DIVISION
P.O. Box 129261, San Diego, CA 92112-9261
858.694.2621 www.sdcdehq.org

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 '25-26($)	**TOTAL**
DENTAL, MEDICAL, or INDUSTRIAL	PLANCHECK BASE FEE	108.00	
	IN ADDITION TO BASE FEE, HOURLY RATE OF $196.00 PER HOUR BASED ON REVIEW TIME.	196.00 X ____ HOURS	