

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

FACILITIES DEVELOPMENT DIVISION

400 "R" Street, Suite 200 ~ Sacramento, California 95811
 700 N. Alameda Street, Suite 2-500, Los Angeles, California 90012

Phone (916) 440-8300 FAX (916) 324-9188
 Phone (213) 897-0166 FAX (213) 897-0168

www.oshpd.state.ca.gov/fdd



ALTERNATE METHOD OF COMPLIANCE

A	Name of Facility:			OSHPD #		
	Email: _____			SUBMITTAL #		
	Address - Street: _____		Phone: _____			
	City: _____		County: _____	FAX#: _____		FACILITY ID #
	Zip: _____					
	Title of Project: _____			DATE:		
B	APPLICATION MADE BY – Name:			<input type="checkbox"/> Alt Method of Compliance		
	Signature: _____			<input type="checkbox"/> Program Flex		
	Date: _____			<input type="checkbox"/> Alt Method of Protection		
	Title _____			<input type="checkbox"/>		
	Address: _____			Local authority approval required.		
	City: _____			OK <input type="checkbox"/> N/A <input type="checkbox"/>		
State: _____						
Zip: _____						
Phone: _____						
FAX: _____						
Who is to be known as the:						
<input type="checkbox"/> Legal Owner/Administrator						
<input type="checkbox"/> Agent for the Legal Owner/Administrator/Letter of Authorization must be attached						
C	Type of Facility:			Type of Facility:		
	<input type="checkbox"/> General Acute Care	<input type="checkbox"/> Skilled Nursing (SNF) and Intermediate Care Facility (ICF)	<input type="checkbox"/> Psychiatric Hospital	<input type="checkbox"/> Other		
D	Description of proposal : _____ (If more space is needed, please attach a separate sheet.)					Applicable Code Section _____
	Reason: _____					
	List of Enclosures: _____					
E	OSHPD RECOMMENDATIONS			DHS LICENSING AND CERTIFICATION RECOMMENDATIONS:		
	Architectural Review _____ Date _____			<input type="checkbox"/> OK	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
	Structural Review _____ Date _____			Signature _____ Date _____		
	Mechanical Review _____ Date _____			Remarks: _____		
	Electrical Review _____ Date _____					
	FLSO Review _____ Date _____					
F	<input type="checkbox"/> Approved <input type="checkbox"/> Conditional Approval <input type="checkbox"/> Denied			Signature: _____ Date: _____		

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INSTRUCTIONS FOR ALTERNATE METHOD OF COMPLIANCE (OSH-FD-126)

- A Enter name as it appears on the facility license. Enter email address, street address, city, county, zip code, phone number, and fax number. Title of project - enter a brief descriptive statement of the work to be performed.

Enter the name of the Facility Representative/Administrator, email address, phone number, fax number, city, state, and zip code. Copies of all correspondence will be sent to the Facility Representative/Administrator. If no Facility Representative/Administrator address is entered, copies of all correspondence will be sent to the Facility address as indicated on the license to the attention of Facility Administrator.

Enter the Office of Statewide Health Planning and Development (OSHPD) project number and OSHPD Facility identification number.

- B This application is to be signed by the legal owner or administrator of the facility, or agent. Indicate in the appropriate boxes the name, signature, date, title, address, phone and fax number of the applicant.

Check the box type of (Alternate Method) review required.

- C Check the box for type facility.

- D Description of proposal - provide complete description of proposed alternate and applicable code section.

Reason for change - List or describe the reasons the items above are requested.

List of enclosures - List the enclosures or attachments. Such enclosures must include architect's title block, facility name, and drawings of alternate.

- E **Leave blank. When returned by OSHPD, staff action taken will be indicated.**
- F **Leave blank. When returned by OSHPD, staff action taken will be indicated.**