

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

FACILITIES DEVELOPMENT DIVISION

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APPLICATION FOR APPROVAL OF ANCHORAGES
FOR FIXED HOSPITAL EQUIPMENT

For Office Use Only

APPLICATION NO.
OPA -

Check whether application is: NEW [] RENEW []

I, _____ (Name of Applicant) _____ (Company)

_____ (Mailing Address) _____ (City) _____ (State) _____ (Zip)

_____ (Telephone) _____ (E-mail Address) hereby apply for the review of
the anchorage for the following fixed hospital equipment as described below:

ENGINEERING RECOMMENDATIONS WILL BE MADE BY:

_____ (Engineer)

_____ (Address) _____ (City) _____ (State) _____ (Zip)

_____ (Telephone) _____ (E-mail Address)

I hereby agree to reimburse the Office of Statewide Health Planning and Development
for the actual costs incurred by the department for review.

_____ (Signature of Applicant) _____ (Date)

_____ (Title)

Date Submitted: _____ Enclosed [] Under Separate Cover []

(Use additional sheets if required)