

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

FACILITIES DEVELOPMENT DIVISION ~

1600 9th Street, Room 420 ~ Sacramento, California 95814

1831 9th Street ~ Sacramento, California 95814

700 N. Alameda Street, Suite 2-500, Los Angeles, California 90012

Phone (916) 654-3362

Phone (916) 324-9090

Phone (213) 897-0166

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FAX (916) 324-9145 North and Central Region

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www.oshpd.state.ca.gov/fdd



Plan Review Application Under Incremental Project (Increment)

A	<p>Name of Facility:</p> <p>E-mail: _____</p> <p>Address - Street: _____ Phone: _____</p> <p>FAX #: _____</p> <p>City: _____ County: _____ Zip: _____</p> <p>Name of Facility Representative/Administrator:</p> <p>E-mail: _____</p> <p>Address - Street: _____ Phone: _____</p> <p>FAX #: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Scope of Project (45 characters max): _____ Applicant Job #: _____</p>	<p>OSHPD#:</p> <p>_____</p> <p>Increment#:</p> <p>_____</p> <p>Facility I.D.#:</p> <p>_____</p>
B	<p>Description of Project:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>OFFICE USE ONLY</p> <p>SUBMITTAL</p> <p><input type="checkbox"/> Field Review</p> <p><input type="checkbox"/> Revised Final</p> <p><input type="checkbox"/> Examination</p> <p><input type="checkbox"/> OTC</p> <p><input type="checkbox"/> Final</p> <p><input type="checkbox"/> Expedite</p> <hr/> <p>DISTRIBUTION</p> <p><input type="checkbox"/> OSHPD</p> <p><input type="checkbox"/> Project File</p> <p><input type="checkbox"/> Rad. Health</p> <p><input type="checkbox"/> L & C</p> <p><input type="checkbox"/> _____</p>
C	<p>Application for Plan Review made by (Name typed): _____</p> <p>Signature: _____ Date: _____</p> <p>Title: _____ Phone #: _____</p> <p>Address: _____ FAX #: _____</p> <p>City: _____ State: _____ Zip: _____ E-mail: _____</p> <p>Who is to be known as: <input type="checkbox"/> Legal Owner/Administrator</p> <p><input type="checkbox"/> Agent for the Legal Owner/Administrator (Authorization must be attached)</p>	<p>OSHPD RECEIPT STAMP</p> <p>_____</p> <p>_____</p> <p>_____</p>
D	<p>Enclosed with this application are the following documents:</p> <p>_____ Plans</p> <p>_____ Specifications</p> <p>_____ Structural Calculations</p> <p>_____ Equipment Anchorage Calculations</p> <p>_____ Design Program (Optional)</p> <p>_____ Testing, Inspection and Observation Program (TIO)</p> <p>_____ Verification of conformance to Local Codes (for New Facilities and Additions)</p> <p>_____</p> <p>_____</p> <p>_____</p>	

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E	Name of Facility (from front page)			OSHPD #
F	Plans and Specifications prepared by the following:			Check discipline in general responsible charge of project
	<input type="checkbox"/>			
	Architect – Firm			
	Individual Responsible:		Lic. #:	E-mail:
	Alternate:		Lic. #:	E-mail:
	Address:			Phone #:
	City:	State:	Zip:	FAX #:
	Structural Engineer – Firm <input type="checkbox"/>			
	Individual Responsible:		Lic. #:	E-mail:
	Alternate:		Lic. #:	E-mail:
	Address:			Phone #:
	City:	State:	Zip:	FAX #:
	Mechanical Engineer – Firm <input type="checkbox"/>			
	Individual Responsible:		Lic. #:	E-mail:
	Alternate:		Lic. #:	E-mail:
	Address:			Phone #:
	City:	State:	Zip:	FAX #:
	Electrical Engineer – Firm <input type="checkbox"/>			
	Individual Responsible:		Lic. #:	E-mail:
	Alternate:		Lic. #:	E-mail:
	Address:			Phone #:
	City:	State:	Zip:	FAX #:
	Civil Engineer – Firm <input type="checkbox"/>			
	Individual Responsible:		Lic. #:	E-mail:
Alternate:		Lic. #:	E-mail:	
Address:			Phone #:	
City:	State:	Zip:	FAX #:	

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INSTRUCTIONS FOR Plan Review Application Under Incremental Project (Increment) (OSH-FD-128)

Do not write in Office Use Only area on this application.

Note: If licensure by the California Department of Health Services is not required by your facility, review by OSHPD is not required and the application is not required. Your application and plans should be submitted to local jurisdictions.

A Enter name as it appears on the facility license. Enter email address, street address, city, county, zip code, phone number and fax number.

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.

Plans returned for correction or stamping will be sent to the Architect or Engineer in general responsible charge of the project as indicated in Section F.

Scope of project - enter a brief (45 characters or less) description statement of the work to be performed. Applicant jobs number - if the facility or architect has a numbering system for projects, enter that project number.

B Description of Project - Describe the work to be performed. Where appropriate, include square footage and quantities.

C This application for plan review is to be signed and dated by the legal owner or administrator of the facility, or agent. If signed by the agent of the legal owner or administrator, the authorization shall be attached to this application. Indicate in the appropriate boxes the name, signature, date, title, address, phone number, fax number, city, state, zip code, and e-mail address of the applicant.

D Indicate the number of documents enclosed.

- Plans and Specifications - Submit one (1) set of plans and specifications for projects involving the structural frame of a health facility.
- Submit one (1) set of plans and specifications for nonstructural health facility projects or for one story, type five skilled nursing facilities.
- Submit copies of structural calculations and equipment anchorage calculations.

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- The applicant may submit a copy of the design program if desired.
- Testing, Inspection, and Observation Program (TIO)
- If verification of conformance to local is required, indicate that these are being included with the application.
- A space is provided for additional information or documents being enclosed with the application.

E Enter the name of the facility from Section A on Page 1.

F Provide information for those disciplines which are involved in this project. Check the box for the discipline, which is in general responsible charge of this project. If plans need to be returned, they will be sent to this individual. For each discipline, provide the name of the individual in responsible charge of the project, e-mail address, his/her license number, an alternate person to contact, e-mail, his/her license number, the address, phone and fax number, city, state, and zip code.