

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 FAX (916) 654-2973
 Phone (916) 324-9090 FAX (916) 324-9145 North and Central Region
 Phone (213) 897-0166 FAX (213) 897-0168

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Application for Plan Review

A	<p>Name of Facility: _____ E-mail: _____</p> <p>Address - Street: _____ Phone: _____</p> <p>_____ FAX #: _____</p> <p>City: _____ County: _____ Zip: _____</p> <p>Name of Facility Representative/Administrator: _____ 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 style="text-align:center;">OFFICE USE ONLY</p> <p>OSHPD #: _____</p> <hr/> <p>Facility I.D. #: _____</p> <hr/> <p style="text-align:center;">SUBMITTAL</p> <p><input type="checkbox"/> Preliminary</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 style="text-align:center;">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> <p><input type="checkbox"/> _____</p> <hr/> <p style="text-align:center;">OSHPD RECEIPT STAMP</p>
B	<p>Description of Project: _____ <input type="checkbox"/> Geotech Only <input type="checkbox"/> Preliminary <input type="checkbox"/> Final</p> <p>_____</p> <p>_____</p> <p style="text-align:center;"><input type="checkbox"/> SB 1953 Mitigation Construction Project (Complete "J")</p> <p>Total Beds</p> <p>Before Construction: _____ After Construction: _____</p>	
C	<p>Kind of Project: <input type="checkbox"/> New Facility (N) <input type="checkbox"/> Addition (A) <input type="checkbox"/> Remodel (R)</p> <p>Type of Facility: <input type="checkbox"/> General Acute Care <input type="checkbox"/> Skilled Nursing (SNF) and Interm. Care Facility (ICF)</p> <p><input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Correctional Treatment Center (CTC) <input type="checkbox"/> Clinic</p>	
D	<p>Legal Owner: _____ Phone: _____</p> <p>_____ FAX #: _____</p> <p>_____ E-mail: _____</p> <p>Address: _____ City: _____ State: _____ Zip: _____</p>	
E	<p>ESTIMATED COSTS</p> <p>1. Estimated construction cost of project (Including Fixed Equipment, excluding Radiology Equipment, Design Fees, Inspection Fees, and Off Site work)\$ _____</p> <p>2. Estimated cost of Radiology Equipment (X-ray, MRI, CT Scans, etc)\$ _____</p> <p>FEES WILL BE BASED UPON: <u>Skilled Nursing Facilities (SNF) are 1.5% (.015) of estimated cost</u></p> <p><u>Acute Care Hospitals (Hosp) fees are 1.64% (.0164) of estimated cost</u></p>	
F	<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>	

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G	Name of Facility (from front page)	OSHPD #
H	Enclosed with this application are the following documents:	
	_____ Plans _____ Specifications _____ Structural Calculations _____ Equipment Anchorage Calculations _____ Design Program (Optional)	_____ Geotechnical Reports (For New Facilities and Additions) Date sent: _____ _____ Testing, Inspection and Observation Program (TIO) _____ Verification of conformance to Local Codes (for New Facilities and Additions) _____ _____
I	Plans and Specifications prepared by the following:	
	Check discipline in general responsible charge of project <input checked="" type="checkbox"/>	
	Architect – Firm <input type="checkbox"/>	
	Individual Responsible:	Lic. #:
	Alternate:	E-mail: Lic. #:
	Address:	E-mail: Phone #:
	City: State: Zip:	FAX #:
	Structural Engineer – Firm <input type="checkbox"/>	
	Individual Responsible:	Lic. #:
	Alternate:	E-mail: Lic. #:
	Address:	E-mail: Phone #:
	City: State: Zip:	FAX #:
	Mechanical Engineer – Firm <input type="checkbox"/>	
	Individual Responsible:	Lic. #:
	Alternate:	E-mail: Lic. #:
	Address:	E-mail: Phone #:
	City: State: Zip:	FAX #:
	Electrical Engineer – Firm <input type="checkbox"/>	
	Individual Responsible:	Lic. #:
	Alternate:	E-mail: Lic. #:
	Address:	E-mail: Phone #:
	City: State: Zip:	FAX #:
	Civil Engineer – Firm <input type="checkbox"/>	
	Individual Responsible:	Lic. #:
	Alternate:	E-mail: Lic. #:
	Address:	E-mail: Phone #:
	City: State: Zip:	FAX #:

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Geotechnical Report – Firm <input type="checkbox"/>			
Individual Responsible:		E-mail:	Lic. #:
Alternate:		E-mail:	Lic. #:
Address:		Phone #:	
City:	State:	Zip:	FAX #:

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**Application for Plan Review
SB 1953- Mitigation Construction Projects**

J	Facility # _____ Bldg. # _____ Bldg. Name _____ Deficiencies Mitigated <div style="border: 1px solid black; height: 100px; width: 100%;"></div> SPC From _____ SPC To _____ SPC Partial/Full _____ NPC From _____ NPC To _____ NPC Partial/Full _____	<p style="text-align:center;">OFFICE USE ONLY</p> OSHPD #: _____ Region: _____ Field Review (FR) Staff: _____ Plan Review (PR) Staff: _____ Date: _____
	Facility # _____ Bldg. # _____ Bldg. Name _____ Deficiencies Mitigated <div style="border: 1px solid black; height: 100px; width: 100%;"></div> SPC From _____ SPC To _____ SPC Partial/Full _____ NPC From _____ NPC To _____ NPC Partial/Full _____	
	Facility # _____ Bldg. # _____ Bldg. Name _____ Deficiencies Mitigated <div style="border: 1px solid black; height: 100px; width: 100%;"></div> SPC From _____ SPC To _____ SPC Partial/Full _____ NPC From _____ NPC To _____ NPC Partial/Full _____	

(Please, duplicate page "J" for more buildings.)

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INSTRUCTIONS FOR APPLICATION FOR PLAN REVIEW (OSH-FD-121)

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 I.

Scope of project - enter a brief (45 characters max) 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 - Check whether this application accompanies a geotechnical report, preliminary report, or final plan submittal. Describe the work to be performed. Where appropriate, include square footage and quantities. Enter total bed count before construction and after construction.

C Check the kind of project. Check Type of Facility as licensed.

D Enter the name of the legal owner, address, phone, fax number, e-mail address, and street address.

E Estimated Cost

Line 1. Enter estimated construction cost of project, including Fixed Equipment to be permanently attached to the building either electrically, mechanically or structurally, but excluding all design fees, inspection fees, off-site work and radiology equipment cost.

Line 2. Estimated cost of radiology equipment. (X-ray, MRI, CT Scans, etc.)

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- F 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.

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

- H 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.
- The applicant may submit a copy of the design program if desired.
- Submit three (3) sets of geotechnical reports for projects involving new facilities and additions to existing facilities. If geotechnical reports were previously submitted to OSHPD, indicate the date they were sent.
- Testing, Inspection, and Observation Program (TIO)
- If verification of conformance to local is required, indicate that these are being included with the application.
- Spaces are provided for additional information or documents being enclosed with the application.

- I 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 address, his/her license number, the street address, phone and fax number, city, state, and zip code.

- J This section is only to be submitted for SB 1953 Mitigation Projects.

Provide the following information for each building in this SB 1953 Mitigation Construction Project:

- Building name and number.
- Deficiencies mitigated by this project.

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- SPC before and after construction; Partial or full Compliance.
- NPC before and after construction; Partial or full Compliance.

Full Compliance should only be chosen if this SB 1953 Mitigation Construction Project meets all requirements for SPC/NPC compliance for the listed Building as designated in the Compliance Plan.