

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT****FACILITIES DEVELOPMENT DIVISION**400 "R" Street, Suite 200, Sacramento, California 95811  
www.oshpd.state.ca.gov/fdd

Phone (916) 440-8300 FAX (916) 324-9188

**Application for 2008 Extension / Delay in Compliance**

<b>A</b>	<b>Name of Facility:</b>		<b>OFFICE USE ONLY</b>	
	E-mail:		<b>OSHPD #:</b>	
	Street Address:		Phone:	
			FAX#:	
	City:		County:	
			Zip:	
	<b>Name of Facility Representative/Administrator:</b>		<b>FACILITY I.D. #:</b>	
	E-mail:		<b>SUBMITTAL</b>	
	Mailing Address:		<input type="checkbox"/> H&S Code 130060 (b) (SB 1801)	
			<input type="checkbox"/> H&S 130063 (SB 2006)	
City:		State:		
		Zip:		
<b>Legal Owner:</b>		Phone:		
Mailing Address:		<input type="checkbox"/> H&S 130060 (a) Health Capacity Diminished		
		<input type="checkbox"/> Other		
City:		State:		
		Zip:		
<b>B</b>	<b>Application Submitted by:</b>			
	<b>OSHPD RECEIPT STAMP</b>			
	Name:			
	Signature:			
	Title:			
	Address:			
	City:			
	State:			
	Zip:			
	Phone #:			
FAX #:				
Who is to be known as: <input type="checkbox"/> Legal Owner/Administrator				
<input type="checkbox"/> Agent for the Legal Owner/Administrator (Authorization must be attached)				
<b>C</b>	<b>Fee Submittal:</b>			
	Filing Fee.....			<b>\$250.00</b>
	<b>Method of Payment:</b>			
	<input type="checkbox"/> Send Invoice to: <input type="checkbox"/> Administrator <input type="checkbox"/> Legal Owner <input type="checkbox"/> Agent for Legal Owner/Administrator			
	<input type="checkbox"/> Check – Made payable to OSHPD			
	<input type="checkbox"/> Visa <input type="checkbox"/> Master Card <input type="checkbox"/> American Express <input type="checkbox"/> Discover/Novus			
	<b>Account Number:</b>		Expiration Date:	
	<b>Billing Address:</b>		<b>Phone:</b>	
	City:		State:	
		Zip Code:		
<b>Card Holder's Name:</b>		<b>Signature:</b>		



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**INSTRUCTIONS**  
**Application for 2008**  
**Extension / Delay in Compliance**  
**(OSH-FDD-384)**

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

- 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 G.

Enter name, phone number, mailing address, city, state and zip code of the Legal Owner.

- B The "Application for 2008 Extension/Delay in Compliance" is to be signed by the legal owner, administrator of the facility, or authorized agent. Indicate in the appropriate boxes the name, signature, title, address, city, state, zip code, phone number and fax number and of the applicant.
- C Fee - The fee for simultaneous submittal for an extension/delay in compliance under SB 1801, SB 2006 or Diminished Health Care Capacity is \$250.00 (nonrefundable). If the requests for SB 1801, SB 2006 or Diminished Health Care Capacity are submitted separately, an additional nonrefundable fee of \$250 is required for each submittal. All fees, plans and reports shall be submitted by the applicant to OSHPD's Facilities Development Division at the following address:

Office of Statewide Health Planning & Development  
Facilities Development Division –  
Hospital Seismic Retrofit Program  
400 "R" Street, Suite 200  
Sacramento, California 95811

The applicant will be billed for the costs of all Seismic Evaluation and Compliance Plan review and approval performed by OSHPD at OSHPD's actual cost for engineering and architectural review. These costs will be credited when the construction documents for the compliance work are submitted to OSHPD. The credit will be in the form of a deduction from the total cost for review of the construction documents by the amount paid by the applicant for review and approval of the Seismic Evaluation Report and Compliance Plan.

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A hospital requesting an exemption pursuant to SB 2006 shall pay the actual expenses incurred by OSHPD and the Division of Mines and Geology for review. The hospital will be billed for these costs upon final approval of the request.

- D Enter the name of the facility from Section A on Page 1.
- E Title of project – check whether the application includes a SB 1801, SB 2006, Diminished Health Care Capacity submittal, or other.
- F Indicate the documents enclosed on application form.
- G For each discipline, provide the name of the individual in responsible charge of the project, his/her registration number, an alternate person to contact, his/her registration number, the address, phone number, city, state, zip code and fax number for the firm. Additionally, check the box for the discipline, which is in general responsible charge of this project.