

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)