



OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

FACILITIES DEVELOPMENT DIVISION – www.oshpd.ca.gov/fdd

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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)