COUNTY OF LOS ANGELES
Public Health

RADIATION SHIELDING PLAN APPLICATION

PURSUANT TO LOS ANGELES COUNTY ORDINANCE 11.22.620, RADIATION SHIELDING DESIGNS MUST BE APPROVED BY THIS OFFICE FOR ALL X-RAY AND P.E.T. / C.T. ROOMS.

INSTRUCTIONS:

1. Must be printed or typed clearly. Where indicated, check the appropriate box. All information must be provided. An incomplete application will result in delays.
2. Plan approval requires payment of fee and completion of Sections 1 through 12.
3. Make check or money order payable to Los Angeles County.
4. Mail the **ORIGINAL** and one copy of this application and room schematics with check or money order to:

RADIATION MANAGEMENT
COUNTY OF LOS ANGELES ENVIRONMENTAL HEALTH
3530 WILSHIRE BOULEVARD, 9TH FLOOR
LOS ANGELES, CA 90010

Internet Address: www.publichealth.lacounty.gov/eh/ep/rad_health/

5. If you have any questions, contact the above office at **(213) 351-7897**

6. PLANS SUBMITTED BY:

NAME: _____ (First) (Last)

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

PHONE: ( ) _____
Area Code

7. JOB/X-RAY MACHINE LOCATION:

NAME & TITLE: _____ (First) (Last) (Title)

FACILITY-D.B.A.: _____

ADDRESS: _____

CITY: _____ ZIP: _____

PHONE: ( ) _____
Area Code

8. Is this an addition to existing equipment at this location? ☐ YES ☐ NO
Is this equipment only replacing existing equipment at this location? ☐ YES ☐ NO
Is this equipment being relocated from another address? ☐ YES ☐ NO

If "YES", what was the name, address and registration number of the previous/current location?

NAME: _____

ADDRESS: _____

CITY: _____ ZIP: _____

REGISTRATION NUMBER: _____

IF PHYSICIST REPORT IS SUBMITTED, SECTIONS 9 AND 10 NEED NOT BE COMPLETED

9. EQUIPMENT AND USE SPECIFICATIONS:

Machine Type:
- ☐ Radiographic
- ☐ Fluoroscopic
- ☐ Therapy
- ☐ Computed Tomography (C.T.)
- ☐ (P.E.T.) / (C.T.)
- ☐ Dental-Coned Beam Volumetric Tomography (CBVT)
- ☐ Dental-Intraoral
- ☐ Dental-Panoramic
- ☐ Dental-Cephalometric
- ☐ Chiropractic
- ☐ Podiatry
- ☐ Veterinary
- ☐ Industrial
- ☐ OTHER (Specify): _____

Maximum Kilovolt peak (kVp) USED _____

Maximum milliampere(mA) _____

Average Exposure Time (Second): _____

Average Number Of Exposures Per Week: _____

Fluoroscopic On-Time (In Minutes per Week): _____

10. PROVIDE BLUE PRINT OR SKETCH OF X-RAY ROOM AND INCLUDE THE FOLLOWING INFORMATION. (SEE ATTACHED SAMPLE) **PROVIDE TWO COPIES**

(a) Compass Orientation (i.e., indicate on sketch the north, south, east, and west directions).
(b) Scale, preferably 1/4-inch = one foot. If sketch is not scaled, indicate the X-ray room dimensions in feet.
(c) Direction of X-ray beam and percentage of use in each direction.
(d) The type and thickness of the construction material in the walls, ceiling and floors if multi-story building.
(e) Type of occupancy in immediate adjoining areas.
(f) In multi-story building, indicate the floor-to-floor distance above and below the X-ray room, and the type of occupancy above and below the X-ray room.
(g) The location of the wall cassette holder, X-ray table, operator position, dental chair, etc. (as applicable).
(h) Indicate the amount or thickness, location, and dimensions of existing or proposed lead shielding.

11. FEE: *** ***CASH CAN BE ACCEPTED*** ***

Plan-Check Fees (effective September 1, 2011 **) & Radiation Shielding Classification:**

$357.00 = Plan-Check Fee per X-ray machine for Dental, Podiatry and Veterinary.

$699.00 = Plan-Check Fee per room for Radiographic, Fluoroscopic, Computed Tomography (C.T.), Therapy, Dental - CBVT, Chiropractic, Industrial and Other types.

$1,398.00 = Plan-Check Fee for Positron Emission Tomography (P.E.T.) / (C.T.) application.

Make check or money order payable to: **"*LOS ANGELES COUNTY*"**

Checks or money orders must be for the exact amount of the fee. Checks must include a name, address and telephone number. This fee is not refundable nor is the application transferable. Post dated and two party checks will not be accepted. Fees subject to change without notice.

12. SELECT BELOW HOW YOU WANT THE REPORT:

☐ Want to be called to pick-up letter
☐ Want letter FAXED
☐ Want letter MAILED

Address the letter to individual in: ☐ Section #6 ☐ Section #7

NAME: _____ TITLE: _____

PHONE: ( ) _____ FAX: ( ) _____
Area Code Area Code

OWNER/REPRESENTATIVE DECLARATION:

I understand that the amount of fee paid is based on declaration of radiation shielding classification of plans submitted. If declaration is incorrect, or any necessary information identified on this form is not provided, I understand that the plans will not be approved.

Print Name: _____ Signature: _____

Title: _____ Date: _____

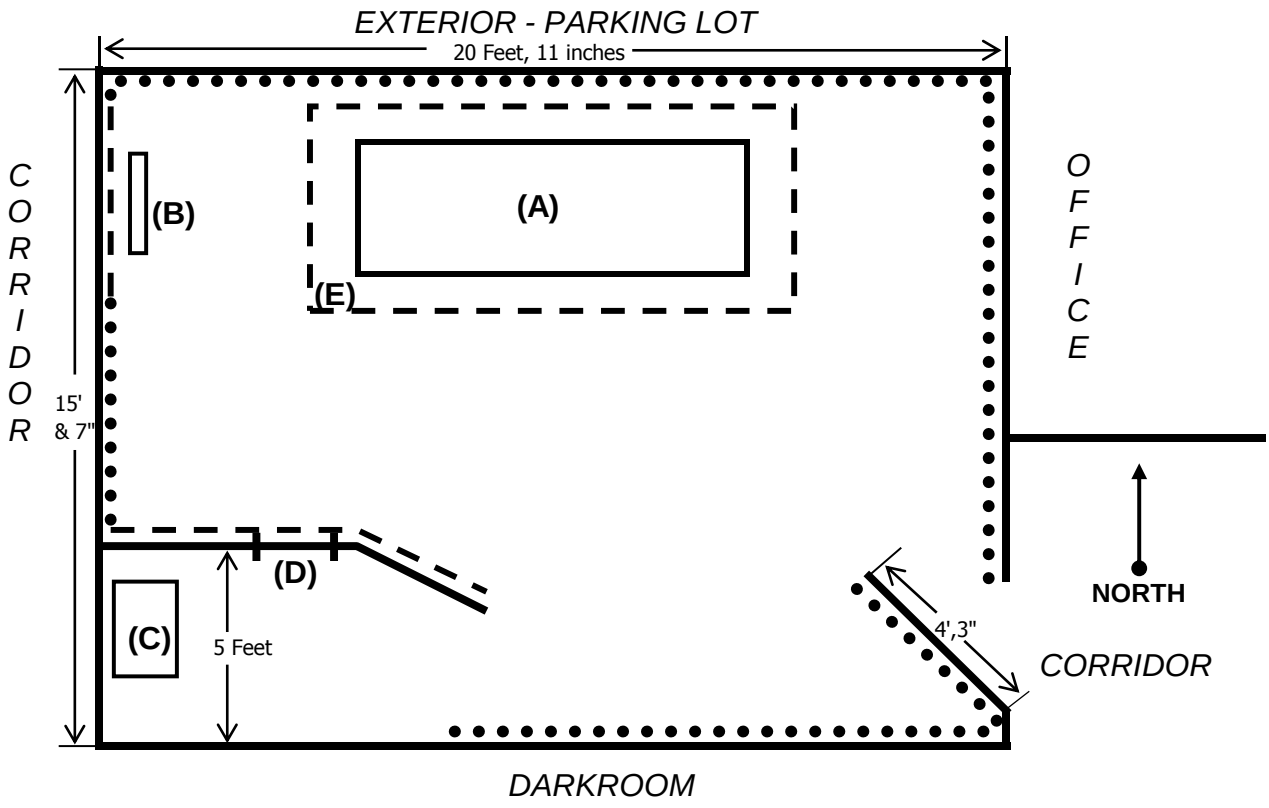
FOR OFFICE USE ONLY

Date Plans Received: _____ Fee: _____

Plans Received By: _____ Invoice Number: _____

Plan-Check Number: _____ Service Request: _____

Sample Radiographic Room



KEY:

Scale: 1/4 inch = 1 Foot

- Two pound lead, 80 inches high
- Four pound lead, 80 inches high
- **(A)** X-ray Table
- **(B)** Vertical Cassette Holder
- **(C)** Control/Operator Location
- **(D)** Four pound lead glass view window
- **(E)** Four pound lead mat centered under table, extending one-foot beyond edges of table.

SPECIFICATIONS FOR RADIOGRAPHIC ROOM:

Location: 2nd Floor of 3-Story Building.

X-ray Use: Tube directed to table = 75%. Tube directed to wall holder = 25%.

Walls: Interior walls with 5/8-inch thick drywall on each side.
Exterior wall with 1-inch thick stucco.

Floor-to-floor distances and occupancies:

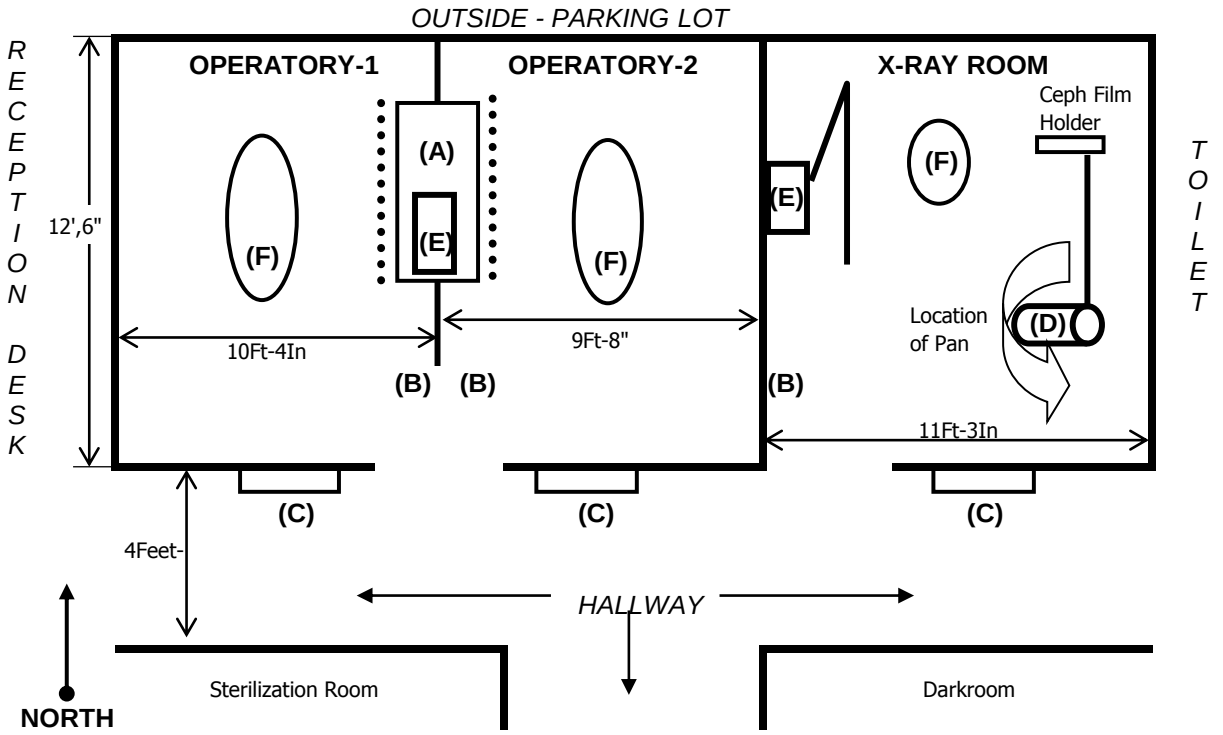
Above: 15 Feet Floor to Floor. Attorney's office above

Below: 12 Feet Floor to Floor. Pharmacy below.

Floors: Ceiling: 3-inch thick lightweight concrete on wood support.

Floor: 5-inch thick normal weight concrete.

Sample Dental Clinic



KEY:

Scale: 1/4 inch = 1 Foot

- **(A) Cabinet with X-ray unit that will swing between rooms. Cabinet doors constructed of 1/2"- plywood, covered with two-pound lead (• • • • • •).**
- **(B) Location of mirrors enabling operator to visualize patient from protected position.**
- **(C) Control Switch / Operator Location**
- **(D) Panoramic / Cephalometric X-ray Unit**
- **(E) Intraoral X-ray Unit**
- **(F) Dental Chair = Patient is facing *NORTH* during X-ray in Operatories 1 & 2. Patient is facing *SOUTH* in the X-ray Room.**

SPECIFICATIONS FOR DENTAL CLINIC:

Location: 1st Floor of 3-Story Building.
Walls: Interior walls with 5/8-inch thick drywall on each side.
Exterior wall with 1-inch thick stucco.
Floor-to-floor distances and occupancy:
Above: 12 Feet Floor to Floor. Attorney's office above.
Below: 9 Feet Floor to Floor. Pharmacy below.
Floors: Ceiling: 5-inch thick normal weight concrete.
Floor: 3-inch thick lightweight concrete on wood support