RADIATION SHIELDING
PLAN CHECK SERVICE REQUEST

Environmental Health Division
Radiation Management
3530 Wilshire Boulevard, 9th floor, Los Angeles, CA 90010
www.publichealth.lacounty.gov/eh | (213) 351-7897

County of Los Angeles Public Health

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. ***Physicist reports are required for C.T., (P.E.T./C.T.) and therapy requests, and are accepted for all other machines.*** For questions, please contact the **Radiation Management Program** at (213) 351-7897 or email **DPHRadiation@ph.lacounty.gov**.

DATE OF REQUEST: _____

 # OF EQUIPMENT FOR THIS REQUEST: _____
 # OF ROOMS FOR THIS REQUEST: _____

SEND REPORT TO			
Select how you would like to receive the report and print the name of the individual to address the letter to.			
☐ Contact by phone to pick up letter ☐ Email ☐ Fax letter ☐ Mail letter			
NAME:	**TITLE:**		
EMAIL ADDRESS:	**PHONE #:**	**FAX #:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**

PLANS SUBMITTED BY			
NAME:	**PHONE #:**		
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**

JOB/X-RAY MACHINE LOCATION			
NAME/REGISTRATION #:	**TITLE:**		
FACILITY D.B.A.:	**PHONE #:**		
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**

ADDITIONAL INFORMATION

1. Is this an addition to existing equipment at this location?
   ☐ NO ☐ YES
2. Is this equipment only replacing existing equipment at this location?
   ☐ NO ☐ YES
3. Is this equipment being relocated from another address?
   ☐ NO ☐ YES
4. Is this submission the result of a Radiation Safety Inspection?
   ☐ NO ☐ YES. **If Yes, please provide name of the Inspector:** _____

If YES on questions 1-3, provide the following information for the previous/current location.		
NAME:		
REGISTRATION #:		
ADDRESS:		
CITY:	**STATE:**	**ZIP:**

EQUIPMENT AND USE SPECIFICATIONS

Use "Additional Equipment" section located on the last page of this form, if needed.

MACHINE 1

MACHINE TYPE:

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

Manufacturer: _____ Model: _____ Room located: _____

Maximum Kilovoltage peak (kVp):	Maximum milliampere (mA):	Average Exposure Time (Second):	Average Number of Exposures Per Week:	Fluoroscopic On-Time (In Minutes Per Week):
_____	_____	_____	_____	_____

MACHINE 2

MACHINE TYPE:

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

Manufacturer: _____ Model: _____ Room located: _____

Maximum Kilovoltage peak (kVp):	Maximum milliampere (mA):	Average Exposure Time (Second):	Average Number of Exposures Per Week:	Fluoroscopic On-Time (In Minutes Per Week):
_____	_____	_____	_____	_____

MACHINE 3

MACHINE TYPE:

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

Manufacturer: _____ Model: _____ Room located: _____

Maximum Kilovoltage peak (kVp):	Maximum milliampere (mA):	Average Exposure Time (Second):	Average Number of Exposures Per Week:	Fluoroscopic On-Time (In Minutes Per Week):
_____	_____	_____	_____	_____

MACHINE 4

MACHINE TYPE:

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

Manufacturer: _____ Model: _____ Room located: _____

Maximum Kilovoltage peak (kVp):	Maximum milliampere (mA):	Average Exposure Time (Second):	Average Number of Exposures Per Week:	Fluoroscopic On-Time (In Minutes Per Week):
_____	_____	_____	_____	_____

PLAN REQUIREMENT

- **Provide a Physicist reports for C.T., (P.E.T./C.T.) and therapy requests.**
- Provide ***one copy*** *of the X-ray room plans and include the following information (see attached sample):*
  a) Compass Orientation (i.e., indicate 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.

FEES & RADIATION SHIELDING CLASSIFICATION

Fees are **non-refundable** and **non- transferable**.	**# OF MACHINES**	**FEES PER MACHINE**
☐ Plan Check Fee per X-ray machine for Low Energy Source (70 kVp and lower).		**$622**
☐ Plan Check Fee per X-ray machine for Medium Energy Source (71 kVp – 300 kVp).		**$977**
☐ Plan Check Fee per X-ray machine for High Energy Source (301 kVp and higher).		**$1,776**
TOTAL DUE:		

SUBMISSION AND PAYMENT

- Requests must be printed or typed clearly, and appropriate boxes checked. All information must be provided. **An incomplete request will result in delays.**
- Plan approval requires payment of fee.
- The Service Request form, plans, supporting documents, and payment can be submitted in-person, electronically, or by mail.
- If you are submitting plans online, an invoice will be generated and emailed to you along with payment instructions.
- **Do not submit your payment until you have received an invoice.**

IN-PERSON:
Submit plans and payment in-person between 8:00 a.m. - 4:30 p.m., Monday through Friday, except for holidays, at:

Radiation Management
Los Angeles County
Department of Public Health
3530 Wilshire Boulevard, 9th floor
Los Angeles, CA 90010

Acceptable forms of in-person payment include electronic payment, cash, check, cashier's check, or money order in the exact amount due. Post dated and two-party checks will not be accepted.

ELECTRONICALLY:
Submit plans and payment online using credit card (Visa, MasterCard, American Express, or Discover), debit card, and electronic check (e-check).

Visit our website for instructions:
https://bit.ly/eh-submitplans

Please note that there is an additional convenience fee charge using online payment.

MAIL:
Mail one copy of this request and room plans to the address below. An invoice will be generated and sent to you along with payment instructions. Make a check, cashier's check, or money order payable to the **County of Los Angeles**, and include your invoice number.
DO NOT MAIL CASH.

Mail to:
Radiation Management
Los Angeles County
Department of Public Health
3530 Wilshire Boulevard, 9th floor
Los Angeles, CA 90010

OWNER/REPRESENTATIVE DECLARATION

I understand the following:

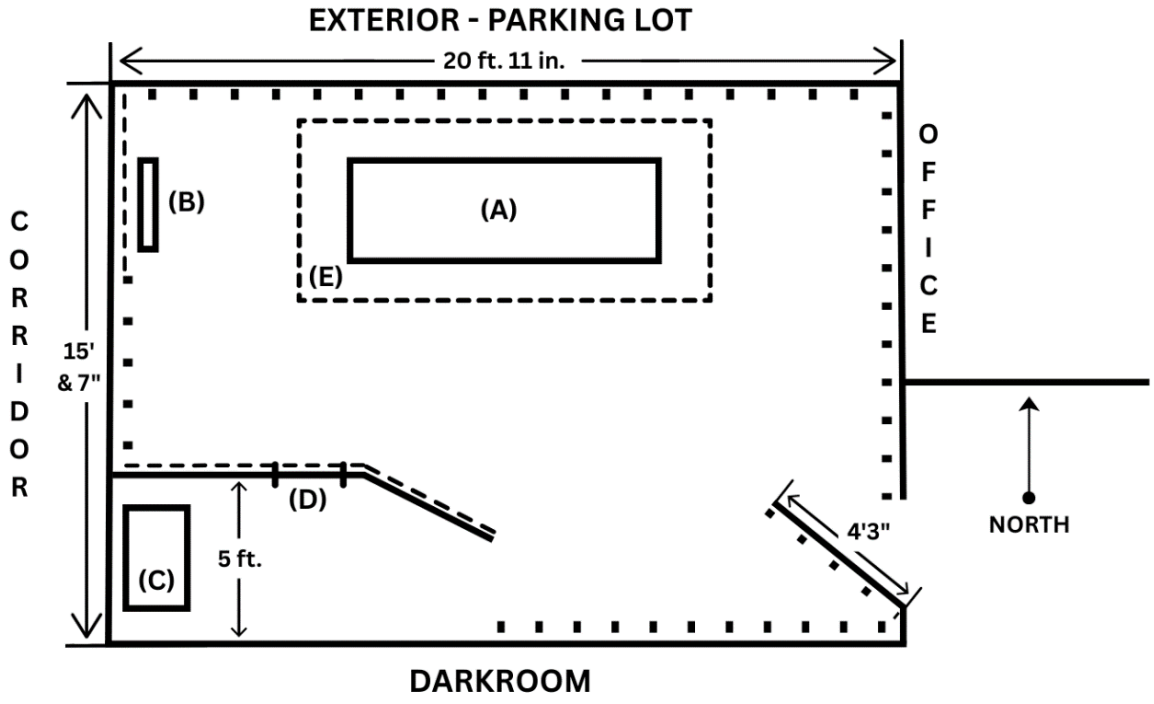
- The amount of fees paid is **NON-REFUNDABLE** and the Service Request is **NON-TRANSFERABLE**.
- Fees are subject to change without notice.
- The amount of the fee paid is based on declaration of radiation shielding classification of plans submitted.
- If declaration is incorrect, or any necessary information identified on this form is not provided, the plans will not be accepted.

Print Name: _____ **Title:** _____

Signature: _____ **Date:** _____

OFFICE USE ONLY		
Plans Received By:	**Date Plans Received:**	**Plan-Check #:**
Fee:	**Invoice #:**	**Service Request:**

SAMPLE OF 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 OCCUPANCY

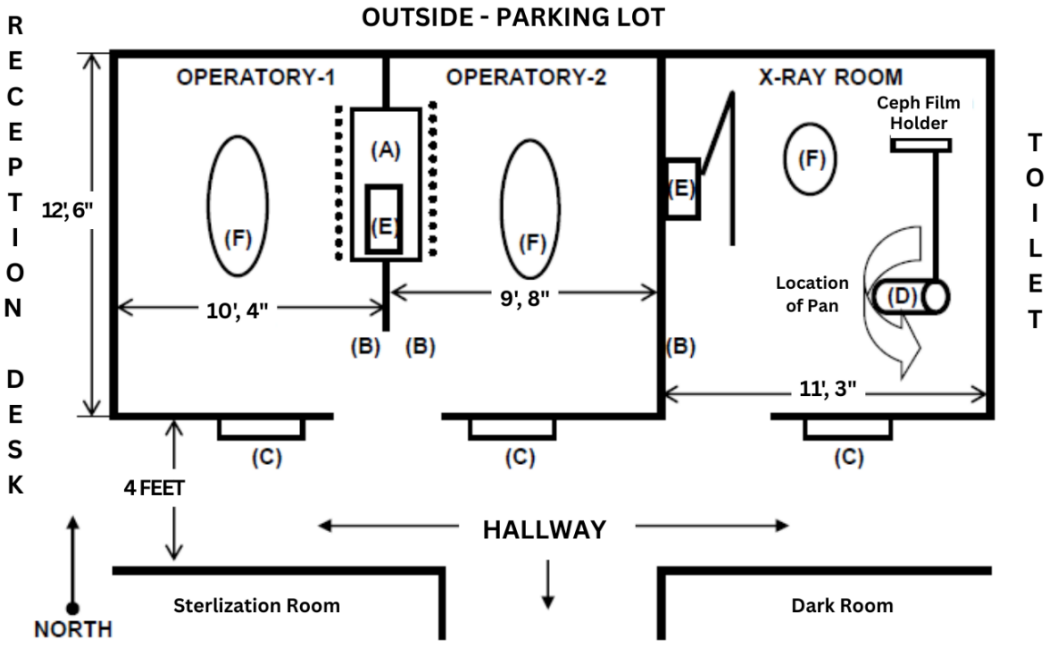
Above: 15 Feet Floor to Floor. Attorney's office above

Below: 12 Feet Floor to Floor. Pharmacy below.

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

Floor: 5-inch thick normal weight concrete.

SAMPLE OF 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/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.

Ceiling: 5-inch thick normal weight concrete.

Floor: 3-inch thick lightweight concrete on wood support.

ADDITIONAL EQUIPMENT

EQUIPMENT AND USE SPECIFICATIONS

MACHINE ____

MACHINE TYPE:

☐ Radiographic ☐ Fluoroscopic ☐ Therapy ☐ (P.E.T.) / (C.T.) ☐ Computed Tomography (C.T.)

☐ Chiropractic ☐ Veterinary ☐ Podiatry ☐ Industrial ☐ Dental-Intraoral

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☐ OTHER (Specify): ______________________________

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☐ OTHER (Specify): ______________________________

Manufacturer: ____________________ Model: ______________________ Room located: ____________________

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