

**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:

ADDRESS: (First) (Last)

CITY:

STATE: ZIP:

PHONE:

()
Area Code**7. JOB/X-RAY MACHINE LOCATION:**

NAME & TITLE:

FACILITY-D.B.A.: (First) (Last) (Title)

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
milliamperere(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

Address the letter to individual in: ☐ Section #6

☐ Want letter FAXED

☐ Section #7

☐ Want letter MAILED

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: _____

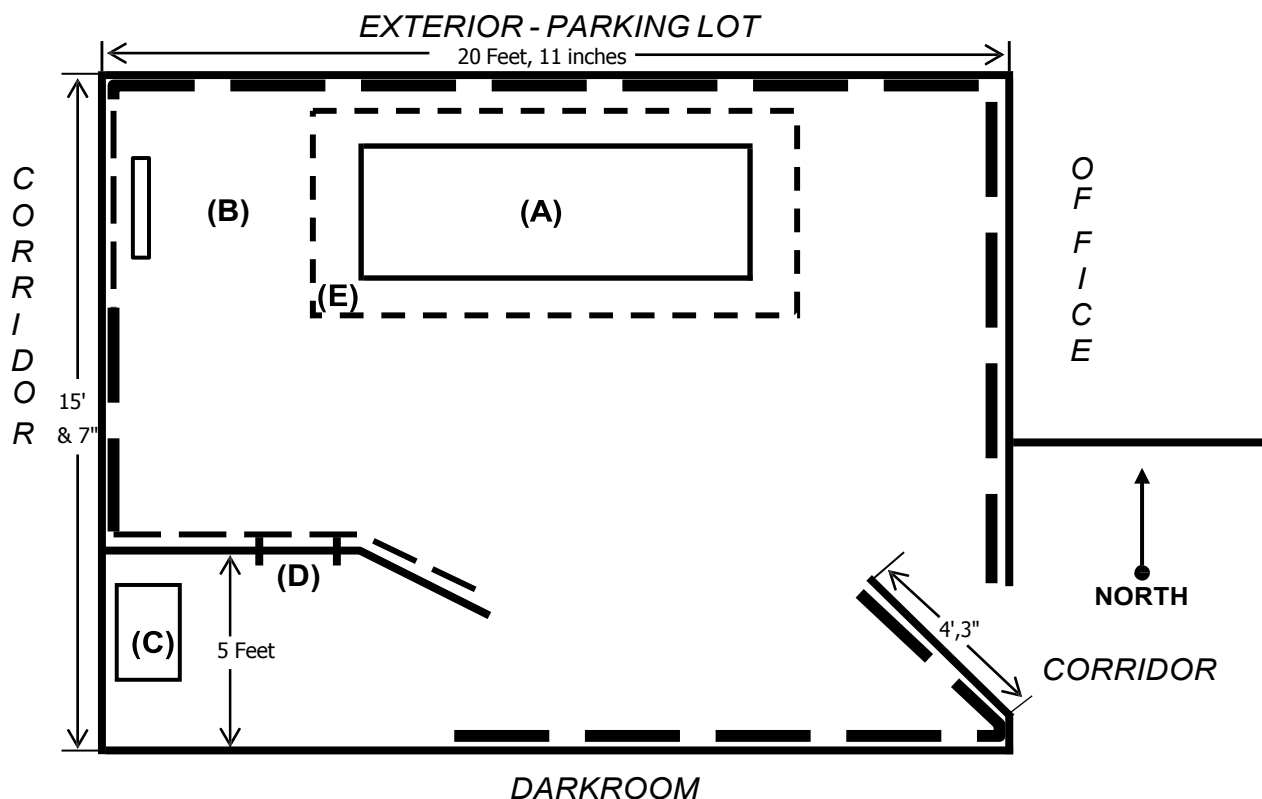
Plans
Received By: _

Invoice Number: _____

Plan-Check
Number: _

Service Request: _

Sample Radiographic Room



KEY:

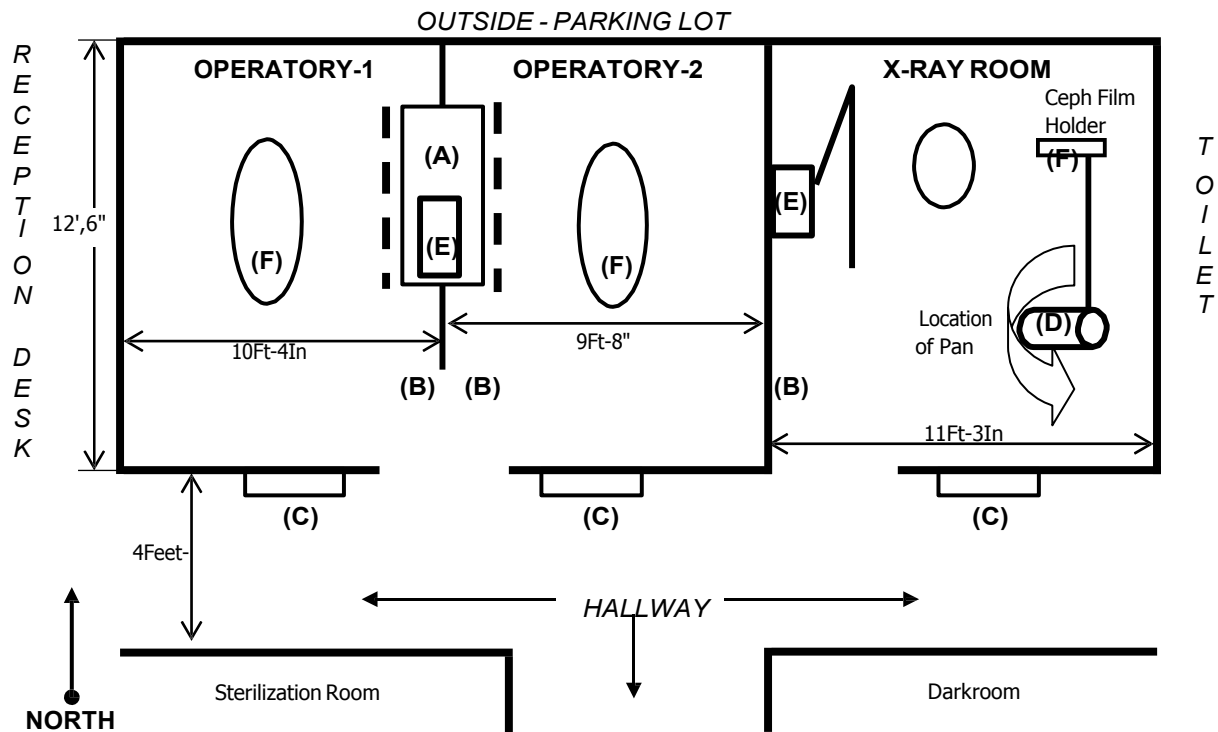
Scale: 1/4 inch = 1 Foot

-  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

To order California Radiation Control Regulations, title 17:

Contact: **Phone:** **Fax:**
1-800-888-3600 415-344-3906

Email:
barclaysccr@thomsonreuters.com

Correspondence Address:
Barclays California Code of Regulations
P.O. Box 2006
San Francisco, CA 94126

Mail Order Address:
Thomson Reuters/Barclays
P.O. Box 95767
Chicago, IL 60694-5767

www.barclaysccr.com/store

Request: Item No. 017-01-550
Initial Code, Radiology Package, Includes 10CFR20
\$105.00 + tax + shipping & handling

This package includes all of the Title 17 Radiologic Health Branch regulations, along with federal radiology regulations. (The CRHB has adopted the current Federal guidelines contained in the 10CFR20—the U.S. Nuclear Regulatory Commission—and these are included in the package.) Compliance with these laws is mandatory—so don't risk having outdated information. Topics include:

- Registration of Sources of Radiation
- Certification of Licensed Users
- Standards for Protection Against Radiation
- Training & Permits for Limited Permit X-Ray Technicians
- And More

To access: California Code of Regulations. title 17

<http://ccr.oal.ca.gov/linkedslice/default.asp?SP=CCR-1000&Action=Welcome>

- ☐ Click on 'List of CCR Titles'
- ☐ Click on 'Title 17 Public Health'
-  DIVISION 1. STATE DEPARTMENT OF HEALTH SERVICES
-  CHAPTER 5. SANITATION (ENVIRONMENTAL)
-  SUBCHAPTER 4. RADIATION
 -  SUBCHAPTER 4.5. RADIOLOGIC TECHNOLOGY
 -  SUBCHAPTER 4.6. NUCLEAR MEDICINE TECHNOLOGY

To access: Code of Federal Regulations. title 10. part 20
Standards for Protection against Radiation

http://www.access.gpo.gov/nara/cfr/waisidx_08/10cfr20_08.html

To access: California Health and Safety Code

<http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=hsc&codebody=&hits=20>

Scroll down the page until you see the starting section **114650**. Sections after this, up to section **115342** relates to radiation protection.

NOTICE TO EMPLOYEES

STANDARDS FOR PROTECTION AGAINST RADIATION

CALIFORNIA RADIATION CONTROL REGULATIONS (CALIFORNIA CODE OF REGULATIONS, TITLE 17, SECTION 30255)

The California Radiation Control Regulations include standards for protection against radiation hazards. The California Department of Public Health has primary responsibility for administering these standards which apply to both employers and employees. Enforcement is carried out by the California Department of Public Health or its authorized inspection agencies.

EMPLOYEES' RESPONSIBILITIES

You should know and understand those California radiation protection standards and your employer's operating and emergency procedures which apply to your work. You should comply with these requirements for your own safety and the safety of others. Report promptly to your employer any condition which may lead to or cause a violation of these standards or employer's operating and emergency procedures.

SCOPE OF THE STANDARDS

The Standards for Protection Against Radiation define:

1. Limits on exposure to radiation and radioactive materials;
2. Actions to be taken after accidental exposure;
3. Working conditions requiring personnel monitoring, safety surveys, engineered controls, and safety equipment;
4. Proper use of caution signs, labels, and safety interlock devices;
5. Requirements for keeping worker exposure records and reporting of such exposures;
6. The requirement for specific operating and emergency procedures for radiation work; and
7. The rights of workers regarding safety inspections.

EMPLOYERS' RESPONSIBILITIES

Your employer is required to:

1. Comply with the requirements of the California Radiation Control Regulations, departmental orders, and license conditions;
2. Post or make available to you copies of the Radiation Control Regulations, any license issued thereunder, and your operating and emergency procedures;
3. Post any notice of violation of radiological working conditions; and
4. Provide you with information on your exposure to radiation.

REPORTS ON YOUR RADIATION EXPOSURE HISTORY

1. California Radiation Control Regulations require your employer to give you a written report if you receive an exposure greater than the limits set in the radiation safety standards. Basic limits for occupational radiation exposure can be found in section 30253 referencing title 10, Code of Federal Regulations, part 20 (10 CFR 20). Limits on exposure to radiation and exposure to concentrations of radioactive material in air are specified in 10 CFR 20, subpart C.
2. If the radiation protection standard, under 10 CFR 20 (subpart F) requires that your radiation exposure be monitored, your employer must, upon your request, give you a written report of your exposures upon termination of your employment, and make available to you the information in your dose records (as maintained under the provisions of 10 CFR 20.2106).
3. Your employer is required to provide you with an annual report of the dose you received in that monitoring year if the dose exceeds 100 millirem, or if you request an annual report.

INSPECTIONS

The Department or one of its contractors will inspect your workplace from time to time to ensure that health and safety requirements are being followed and that these requirements are effective in protecting you. Inspectors may confer privately with you at the time of inspection. At that time you may direct the inspector's attention to any condition you believe is or was a violation of the safety requirements.

In addition, if you believe at any time that any health and safety requirements are being violated, you or your workers' representative may request that an inspection be made by sending a complaint to the Department of Public Health or other official agency. Your complaint must describe the specific circumstances of the apparent violation and must be signed by you or your workers' representative. The Department is required to give your employer a copy of any such complaint. Names may be withheld at your request. You should understand, however, that the law protects you from being discharged or discriminated against in any way for filing a complaint or otherwise exercising your rights under the California Radiation Control Regulations.

POSTING REQUIREMENTS

Copies of this notice must be posted in a sufficient number of places in every establishment where employees are employed in activities regulated by the California Radiation Control Regulations, to permit employees working in or frequenting any portion of a restricted area to observe a copy on the way to or from their place of employment.

FOR RADIOLOGICAL EMERGENCY ASSISTANCE (24/7), PHONE 1-800-852-7550

To contact the Radiologic Health Branch, phone (916) 327-5106 or go to:

<http://www.cdph.ca.gov/programs/Pages/RadiologicHealthBranch.aspx>

RADIATION MACHINE REGISTRATION FOR CHANGES TO REGISTRANT OR MACHINE INFORMATION

[Click here](#) for instructions.

For changes in ownership, use [RH 2261N](#) (New Registrant) or
[RH 2261W](#) (Withdrawal of Registration).

TYPE OF ACTION. Choose all actions that apply. **Complete sections A, F, G, and H for all actions.**

- If changing registrant information, also complete section B.
- If changing registered machine information, also complete section C.
- If removing one or more registered machine(s), also complete section D.
- If adding one or more radiation machine(s), also complete section E.

A: REGISTRANT INFORMATION

Registrant (name of facility, business, or practice)	Registration Number	☐ Mammography Provider
Physical Address (street number and name)	City	State
		Zip Code

B: CHANGES TO REGISTRANT INFORMATION

Provide new or corrected information only. A completed field indicates a change.

Registrant (name of facility, business, or practice)	Business Phone Number
Type of Facility, Business, or Practice (e.g. dental, medical, veterinary, etc.)	☐ Mammography Provider No Longer a Mammography Provider
Physical Address (street number and name)	City
	State
	Zip Code
Mailing Address (street number and name)	City
	State
	Zip Code

FOR RADIOLOGIC HEALTH BRANCH USE ONLY

C: CHANGES TO REGISTERED MACHINE INFORMATION

Provide new or corrected information only. A completed field indicates a change.

Registered Machine	Manufacturer		Model	Room Name or Number
Changes (provide new or corrected information only)	Manufacturer		Model	Room Name or Number
	Number of X-ray Tubes, Waveguides, or Electron Guns	Type Code	Additional Information	
FOR RADIOLOGIC HEALTH BRANCH USE ONLY				

Registered Machine	Manufacturer		Model	Room Name or Number
Changes (provide new or corrected information only)	Manufacturer		Model	Room Name or Number
	Number of X-ray Tubes, Waveguides, or Electron Guns	Type Code	Additional Information	
FOR RADIOLOGIC HEALTH BRANCH USE ONLY				

Registered Machine	Manufacturer		Model	Room Name or Number
Changes (provide new or corrected information only)	Manufacturer		Model	Room Name or Number
	Number of X-ray Tubes, Waveguides, or Electron Guns	Type Code	Additional Information	
FOR RADIOLOGIC HEALTH BRANCH USE ONLY				

D: REMOVING REGISTERED MACHINE(S) Complete and submit [RH 2261W](#) instead if you are no longer in possession of any radiation machines or all radiation machines in your possession have been made incapable of producing radiation.

Registered Machine	Manufacturer	Model	Room Name or Number
Removal Action (check one)	☐ This machine is no longer in my possession. ☐ This machine has been made incapable of producing radiation.	Removal Action Date (mm/dd/yyyy)	
Additional Information			
FOR RADIOLOGIC HEALTH BRANCH USE ONLY			

Registered Machine	Manufacturer	Model	Room Name or Number
Removal Action (check one)	☐ This machine is no longer in my possession. ☐ This machine has been made incapable of producing radiation.	Removal Action Date (mm/dd/yyyy)	
Additional Information			
FOR RADIOLOGIC HEALTH BRANCH USE ONLY			

Registered Machine	Manufacturer	Model	Room Name or Number
Removal Action (check one)	☐ This machine is no longer in my possession. ☐ This machine has been made incapable of producing radiation.	Removal Action Date (mm/dd/yyyy)	
Additional Information			
FOR RADIOLOGIC HEALTH BRANCH USE ONLY			

E: ADDING MACHINE(S) Do not add machines that you have already registered.

Manufacturer	Model	Type Code (see instructions)	
Number of X-ray Tubes, Waveguides, or Electron Guns	Room Name or Number	Acquired Date (mm/dd/yyyy)	Form FDA 2579
Additional Information			
FOR RADIOLOGIC HEALTH BRANCH USE ONLY			

Manufacturer	Model	Type Code (see instructions)	
Number of X-ray Tubes, Waveguides, or Electron Guns	Room Name or Number	Acquired Date (mm/dd/yyyy)	Form FDA 2579
Additional Information			
FOR RADIOLOGIC HEALTH BRANCH USE ONLY			

Manufacturer	Model	Type Code (see instructions)	
Number of X-ray Tubes, Waveguides, or Electron Guns	Room Name or Number	Acquired Date (mm/dd/yyyy)	Form FDA 2579
Additional Information			
FOR RADIOLOGIC HEALTH BRANCH USE ONLY			

F: FACILITY CONTACT INFORMATION. Enter the individual that a Radiologic Health Branch representative may contact regarding any information provided on this form.

Name	Phone Number	E-mail Address
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G: SIGNATURE OF AUTHORIZED REPRESENTATIVE.

I declare under penalty of perjury under the laws of the State of California that the information submitted on this form and on any attachments is true and correct. I agree to abide by all laws and regulations that pertain to the operation and registration of the radiation machine(s) for which I am applying including but not limited to those laws and regulations governing the establishment, implementation, and maintenance of a radiation protection program.

Name	Title/Position
Signature	Date

H: RECORDKEEPING/SUBMISSION

Submit all pages. Keep a copy for your records. Do not submit multiple copies of the same completed form. No payment is required at this time. **Mail the original** with supporting documents to:

**ATTN: Registration and Certification Support Unit
California Department of Public Health
Radiologic Health Branch
MS 7610
P.O. Box 997414
Sacramento, CA 95899-7414**

For more information, please visit our website at <http://cdph.ca.gov/rhb> or call (916) 327-5106.

FOR RADIOLOGIC HEALTH BRANCH USE ONLY

RADIATION MACHINE REGISTRATION FOR NEW REGISTRANTS

[Click here](#) for instructions.

A: REGISTRANT INFORMATION

Registrant (name of facility, business, or practice)			Business Phone Number	
Type of Facility, Business, or Practice (e.g. dental, medical, veterinary, etc.)				☐ Mammography Provider
Physical Address (street number and name)	City	State	Zip Code	
Mailing Address (street number and name)	City	State	Zip Code	

B: MACHINE INFORMATION List all radiation machines that you possess.

Manufacturer	Model	Type Code (see instructions)	
Number of X-ray Tubes, Waveguides, or Electron Guns	Room Name or Number	Acquired Date (mm/dd/yyyy)	Form FDA 2579
Additional Information			
FOR RADIOLOGIC HEALTH BRANCH USE ONLY			

Manufacturer	Model	Type Code (see instructions)	
Number of X-ray Tubes, Waveguides, or Electron Guns	Room Name or Number	Acquired Date (mm/dd/yyyy)	Form FDA 2579
Additional Information			
FOR RADIOLOGIC HEALTH BRANCH USE ONLY			

C: FACILITY CONTACT INFORMATION. Enter the individual that a Radiologic Health Branch representative may contact regarding any information provided on this form.

Name	Phone Number	E-mail Address

D: SIGNATURE OF AUTHORIZED REPRESENTATIVE.

I declare under penalty of perjury under the laws of the State of California that the information submitted on this form and on any attachments is true and correct. I agree to abide by all laws and regulations that pertain to the operation and registration of the radiation machine(s) for which I am applying including but not limited to those laws and regulations governing the establishment, implementation, and maintenance of a radiation protection program.

Name	Title/Position
Signature	Date

E: RECORDKEEPING/SUBMISSION. Submit all pages. Keep a copy for your records. Do not submit multiple copies of the same completed form. No payment is required at this time. **Mail the original** with supporting documents to:

**ATTN: Registration and Certification Support Unit
California Department of Public Health
Radiologic Health Branch
MS 7610
P.O. Box 997414
Sacramento, CA 95899-7414**

For more information, please visit our website at <http://cdph.ca.gov/rhb> or call (916) 327-5106.

FOR RADIOLOGIC HEALTH BRANCH USE ONLY

**RADIATION MACHINE REGISTRATION FOR
WITHDRAWAL OF REGISTRATION**

[Click here](#) for instructions.

A: REGISTRANT INFORMATION

Registrant (name of facility, business, or practice)	Registration Number	☐ Mammography Provider
Physical Address (street number and name)	City	State
		Zip Code

B: REASON FOR WITHDRAWAL See instructions for which box to check.

- ☐ Registrant is no longer in possession of any radiation machines.
- ☐ All radiation machines that the registrant is in possession of have been made incapable of producing radiation.

C: SIGNATURE OF AUTHORIZED REPRESENTATIVE.

I declare under penalty of perjury under the laws of the State of California that the information submitted on this form and on any attachments is true and correct. I agree to abide by all laws and regulations that pertain to the operation and registration of the radiation machine(s) for which I am applying.

Name	Title/Position	Signature
E-mail Address	Phone Number	Date

D: RECORDKEEPING/SUBMISSION. Keep a copy for your records. Do not submit multiple copies of the same completed form. **Mail the original** with supporting documents to:

ATTN: Registration and Certification Support Unit
California Department of Public Health
Radiologic Health Branch
MS 7610
P.O. Box 997414
Sacramento, CA 95899-7414

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FOR RADIOLOGIC HEALTH BRANCH USE ONLY

	Quality Assurance (Dental Radiography)	
	Reference Film	C,V,I
	Reference Film meeting interpreting dentist's criteria for image density, contrast sharpness and overall quality [30311.1 (a)(1)]	
1	Available / Selected?	
2	Used in daily comparisons of dental radiographs? [30311.1 (a)(2)]	
	Corrective Actions	C,V,I
3	Corrective action taken when observable changes occur in clinical radiographic image density, contrast, sharpness and overall quality? [30311.1 (a)(3)]	
4	Records available? [30311.1 (a)(4)]	
5	Maintained for one year? [30311.1 (a)(4)]	
6	Corrective action, as directed by the Department, is taken if the entrance exposure to an adult patient, is found by the department to be outside the range of the specified table? { <i>attached</i> }. [30311.1 (a)(5)]	
COMMENTS:		