



City of Bakersfield  
**Development Services,  
 Building Division**  
 1715 Chester Avenue  
 Bakersfield, CA 93301  
 (661) 326-3720

**Clarification of all  
 Medical Facilities  
 for the purpose of  
 Plan Review, Inspection and Verification for  
 OSHPD 3 Requirements**

**Form No**

**Project Address:** \_\_\_\_\_ **Business Name:** \_\_\_\_\_ **Permit No:** \_\_\_\_\_

**INSTRUCTIONS:** Required at time of permit application for any medical or treatment project.  
 Provide four (4) sets of plans and complete both pages of form with appropriate signatures.

Prior to plan review and issuance of permit applicant to pay all applicable fees associated with plan review, inspection of construction and verification of OSHPD 3 and State Fire Marshal requirements.

Please indicate Title 24 California Building Code occupancy classification(s) of your project: \_\_\_\_\_

Please provide a description of all procedures preformed at your project:

\_\_\_\_\_

\_\_\_\_\_

Please indicate all levels of sedation (general anesthesia) performed at your project:

- No sedation
- Partial sedation (twilight)
- Total sedation
- Other sedation \_\_\_\_\_

Please indicate total number of patients your project will accommodate: \_\_\_\_\_

(Total Number of Patients is base upon maximum occupancy of CBC Table 1004.1 and Equation where general anesthesia used is:  
 Number of patients = One patient per preoperative room bed + One patient per operating room bed +One patient per recovery room bed)

Please indicate that your project will accommodate (check box that applies to your project):

- only ambulatory patients.
- only non-ambulatory patients.
- both ambulatory and non-ambulatory patients.

Please indicate if your project may at anytime render patients incapable of unassisted self-preservation or if patients at anytime may be restrained in any manner (check box that applies to your project):

- Yes.
- No.

Please specify if your project is an outpatient health care facility that provides direct medical, surgical, dental, optometric or podiatric advice, services, or treatment to patients who remain less than 24 hours:

- Yes.
- No.

Please check all boxes that apply to your project as defined by OSHPD:

**Primary Care Clinic:**

- Abortion Services
- Clinical Facilities
- Optometric Clinic
- Dental Clinic
- Podiatric Clinic
- Free Clinic
- Community Clinic
- Employee Clinic
- Psychology Clinic
- Examination Areas

**Other:**

- \_\_\_\_\_

**Specialty Clinic:**

- Surgical Clinic
- Chronic Dialysis Clinic
- Ambulatory Surgery Center
- Hospital Outpatient Clinic
- Alternative Birth Center
- Rehabilitation Clinic
- Occupational Therapy Services
- Physical Therapy
- Audiology Service
- Speech Pathology
- Cystoscopic Areas
- Postanesthesia Recovery

**Non-Hospital Clinic:**

- Non-Hospital Clinic
- Dermatology Clinic
- Treatment Service Areas
- Cast or Fracture Areas

**Birthing Clinic:**

- Birthing Clinic

**Health Facility Systems:**

- Gas Vacuum Systems
- Hyperbaric Facilities
- Laboratories
- Ethylene Oxide Sterilization
- Water Installations

# Plan Review, Inspection and Verification for OSHPD 3 Requirements (cont.)

Project Address: \_\_\_\_\_ Business Name: \_\_\_\_\_ Permit No: \_\_\_\_\_

### State Fire Marshal Office NFPA 101 review and approval (check and complete box applies to your project):

(The designer to contact the Office of the State Fire Marshal at (916) 445-8200 for further information)

- 1. Hospital Governing Authority *or* Building Owner *or* California Architect *or* Engineer **will** obtain from "State Fire Marshal Office" (SFM) *any* required plan review, inspection of construction and verification requirements as specified in NFPA 101 Life and Safety Code.
- 2. Exempt per NFPA Code Section: \_\_\_\_\_  
(Reference applicable Regulation Titles and Sections Numbers stating exemption)

### Please check the appropriate box that applies to your project:

(The designer to contact the Office of Statewide Health Planning and Development at (916) 326-3600 for further information)

- 1. This project **will** be a DPH or State Licensed or Certified as an OSHPD 3 Clinic or Project.
- 2. This project **will not** be a DPH or State Licensed or Certified as an OSHPD 3 Clinic or Project.

### Please check the appropriate box that applies to your project:

(The designer to contact the Office of Statewide Health Planning and Development at (916) 326-3600 for further information)

- 1. This project **will** be a Licensed or Certified as a Medicare and/or Medicaid Clinic or Project.
- 2. This project **will not** be a Licensed or Certified as a Medicare and/or Medicaid Clinic or Project.

### I am requesting the City of Bakersfield per

#### California Building Code Section 1226 and Health and Safety Code Sections 1200 or 1250:

- 1. Provide **only** plan review and verification for OSHPD 3 requirements.
- 2. Provide **only** inspection of construction and verification for OSHPD 3 requirements.
- 3. Provide **both** plan review, inspection of construction and verification for OSHPD 3 requirements.
- 4. "Bakersfield City Building Department" **will not** be required to provide for this project *any* of the following: plan review, inspection of construction and verification for OSHPD 3 or *any* other medical requirements **because** (check box that applies):
  - 4A. "Office of Statewide Health Planning and Development" (OSHPD) **will** provide *all* of the following: plan review, inspection of construction and verification for OSHPD 3 requirements.
  - 4B. Project is **Medical Office Building** **only** and **not** subject to any required licensing or certification.
  - 4C. Exempt per CBC or H&S Code Section: \_\_\_\_\_  
(Reference applicable Regulation Titles and Sections Numbers stating exemption)

### I certify under penalty of perjury that I have the knowledge and authority to make this declaration: (Both the Hospital Governing Authority and California Registered Designer to complete and sign)

(1) \_\_\_\_\_  
Hospital Governing Authority Authorized Signature or Building Owner Signature Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Title \_\_\_\_\_

Contact Mailing Address \_\_\_\_\_ Contact Telephone \_\_\_\_\_

(2) \_\_\_\_\_  
California Architect Signature or Structural/Civil Engineer Signature Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Title and License Number \_\_\_\_\_

Contact Mailing Address \_\_\_\_\_ Contact Telephone \_\_\_\_\_