



## **Declaration of Request for Plan Review, Inspection and Certification for OSHPD 3 Clinic Requirements**

**Building Permit Number:**

**Address of Clinic:**

This Clinic will be a State Licensed OSHPD 3 Clinic.

This Clinic will not be a State Licensed OSHPD 3 Clinic

If a State Licensed Clinic, please specify the type of Clinic:

Primary care Clinic:

Free Clinic

Community Clinic

Employee Clinic

Optometric Clinic

Psychology Clinic

Specialty Clinic:

Surgical Clinic

Chronic Dialysis Clinic

Rehabilitation Clinic

Alternative Birth Center (ABC)

Freestanding Outpatient Clinical  
Service of a Hospital Service:

I am requesting the City of Santa Clara:

Provide plan review and certification for this State Licensed OSHPD 3 Clinic.

Provide Inspection and certification for this State Licensed OSHPD 3 Clinic.

I certify under penalty of perjury that I have the knowledge and authority to make this declaration:

Clinic Governing Authority

**Name:**

**Signature:**

**Date:**

## Plan Review Certification

The City of Santa Clara has provided Building, Mechanical, Electrical and Plumbing plan review verification under OSHPD 3 requirements for this Clinic.

### Building Plans Examiner

**Name:**

**Signature:**

**Date:**

### Electrical Plans Examiner

**Name:**

**Signature:**

**Date:**

### Mechanical & Plumbing Plans Examiner

**Name:**

**Signature:**

**Date:**

## Contact Information

**Permit Center:** 408-615-2420 | **Email:** [permitcenter@santaclaraca.gov](mailto:permitcenter@santaclaraca.gov)

**Building Division:** 408-615-2440 | **Email:** [building@santaclaraca.gov](mailto:building@santaclaraca.gov)