Department of Labor and Industries
Factory Assembled Structures
PO Box 44430
Olympia WA 98504-4430

FedEx/UPS Delivery:
Department of Labor and Industries
7273 Linderson Way SW
Tumwater WA 98501-5414

PLAN APPROVAL REQUEST CONVERSION VENDOR/ MEDICAL UNITS

Company/Owner Name		
Address		
City	State	Zip
Telephone number	Fax number	

Contact person	Date	Fee enclosed **$**
Email address		
Signature	Telephone number	Fax number

See WAC 296-150V-3000 for fees required

New plan design	Addendum	Resubmittal	One time filing fee
$	$	$	$

Size of Vendor/Medical Unit: Width _____ Length _____ Area (Sq Ft.) _____

Electrical Service: Amps _____

	Attached	N/A	
Concentrated load calculations or test proposals			
Panel box schedule/electric load calc's			
Floor plan drawing			
Gas piping drawing			
Water supply drawing			
Drain and vent drawing			

Operating pressure _____ No of fixtures _____ Total length _____

For Department Use Only		
Fee ledger sheet number	Application ID	Plan approval number
Date approved	Expiration date	

RESET

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PLAN APPROVAL REQUEST CONVERSION VENDOR/ MEDICAL UNITS

Company/Owner Name (1)		
Address		
City	State	Zip
Telephone number	Fax number	

Contact person (2)	Date	Fee enclosed **$**
Email address		
Signature	Telephone number	Fax number

See WAC 296-150V-3000 for fees required

New plan design $ (3) | Addendum $ (4) | Resubmittal $ (5) | One time filing fee $ (6)

Size of Vendor/Medical Unit: Width (7) Length _____ Area (Sq Ft.) _____

Electrical Services: Amps (8) _____

	Attached	N/A	
Concentrated load calculations or test proposals			
Panel box schedule/electric load calc's (9)			
Floor plan drawing			
Gas piping drawing			
Water supply drawing			
Drain and vent drawing			

Operating pressure (10) _____ No of fixtures _____ Total length _____

For Department Use Only		
Fee ledger sheet number	Application ID	Plan approval number
Date approved	Expiration date	

Instructions for completing
Plan Approval Request Conversion and Vendor/Medical Units

1. Provide owner name, address, and telephone number and your fax number if available.

2. Print and sign the name of the contact person responsible for this plan and for information. Include on this line the date the plan was sent to the Department and the total fee enclosed for this Vendor/Medical Unit. See WAC 296-150V-3000 for the fee schedules. Provide an extension number or direct line and FAX number if available for the contact person. Provide the email address of the contact person.

3. Use this line if a new plan is submitted for the first time. Indicate the appropriate fee to be paid. See WAC 296-150V-3000.

4. This line is to be used if this submittal is an ADDENDUM to a previously approved plan. Indicate the fee paid and the approved plan number that you wish to amend.

5. Fill in this line only if this is a resubmittal response to a previously reviewed and rejected plan. Indicate the fee required for resubmittal. See WAC 296-150V-3000.

6. This is a ONE TIME fee for first-time applicants. This applies to MANUFATURERS ONLY.

7. Show the width, length, and the square footage of the Vendor/Medical Unit.

8. Provide the size of the Electrical Service for the whole Vendor/Medical Unit. The size of the electrical service is usually the same as the main breaker.

9. This section is meant to act as a checklist for some of the information that may be necessary to approve the Vendor/Medical Unit. Not all elements may be applicable to your plan and as such may be 'N/A'.

10. Provide plumbing system operating pressure whenever plumbing fixtures are installed in the Vendor/Medical Unit. Provide the number of individual fixtures that are installed in the Vendor/Medical Unit. Provide the total length of the water supply system. For self contained Vendor/Medical Units, the length is from the pump to the most remote fixture.