Regional Hospital, Main Campus, 1 Main Street, Boston, MA 02111

Facility’s Licensed Name or Proposed Name  Address, including zip code

If Hospital/Clinic Satellite, Name  Address, including zip code

Ambulatory Care Department, Main Building, Third Floor

Hospital/Clinic Department  Building/Floor Location

I HEREBY REQUEST THE DEPARTMENT WAIVE COMPLIANCE WITH THE REGULATION OR REQUIREMENT:

1.A: FOUND AT:  
(Regulation/Requirement Citation)  
AIA Guidelines 2001, Section 9.2.H1

1.B: THAT REQUIRES (Text of Regulation/Requirement):

Minimum public corridor width shall be 5 feet.

2.A: DESCRIPTION OF PROPOSED ALTERNATIVE TO COMPLIANCE WITH THE REQUIREMENT:

2.B: HOSPITALS AND LONG TERM CARE FACILITIES – WHAT WILL BE DONE TO COMPENSATE; CLINIC AND HOSPICE – HOW THE PROVIDER WILL REMAIN IN SUBSTANTIAL COMPLIANCE:

Corridor #001 is 4'-6" wide on a length of 20 feet.

That corridor is connected to 5'-0" wide corridors at both ends.
Regional Hospital, Main Campus, 1 Main Street, Boston, MA 02111

Regulation/Requirement Citation: AIA Guidelines 2001, Section 9.2.H1.a

3. PROVIDER'S EXPLANATION OF HOW MEETING THE REQUIREMENT AS WRITTEN WOULD CAUSE UNDUE HARDSHIP:

The corridor width is limited by existing structural columns. Structural construction work that would be involved in widening the corridor would cost an estimated $100,000 and would disrupt services on the floor above. The additional cost to this limited renovation project would be excessive in comparison to the estimated total cost of construction.

4. PROVIDER'S ASSURANCE THAT APPROVAL OF THE WAIVER: (A) WILL NOT LIMIT THE CAPACITY TO PROVIDE ADEQUATE CARE; AND, (B) DOES NOT JEOPARDIZE/AFFECT PATIENT OR RESIDENT HEALTH AND SAFETY:

Corridor #001 leads to 6 examination rooms only, therefore 2-way traffic is anticipated to be limited.

The 5'-0" wide corridors connected to Corridor #001 at both ends will allow for wheelchair turnaround space.

The reduced corridor width complies with the State Building Code.

FACILITY AUTHORIZED REPRESENTATIVE:

Name: ____________________________
Title: ____________________________
Mailing Address: __________________
Tel #: ____________________________

Signature: _________________________

FACILITY CLINICAL REPRESENTATIVE:

Name: ____________________________
Title: ____________________________
Tel #: ____________________________

Signature: _________________________

For DPH Use Only: The waiver identified above is approved, approved with conditions or denied as indicated below.

Evaluated by: ______________________  ___ / ___ / ___  □ Approved □ Approved w/Conditions □ Denied

Reviewed by: ______________________  ___ / ___ / ___  □ Approved □ Approved w/Conditions □ Denied

CONDITIONS:

Note: This waiver may be evaluated during on-site visits by Department staff at the facility. The Department reserves the right to revoke the waiver approvals if deficiencies are cited that indicate that the waivers adversely affect patient or resident health and safety.