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Information Request Form Written Safety Plans

Instructions

Please fill out this form with as much detail as possible. Provide complete and proper information; no abbreviations please. Information will appear exactly as entered, so be sure to check spelling.

Should you have any questions, please call 800.55.HELPS.

1. Construction Safety Program

General Information

Date _____

Company _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Employees (FT & PT) _____ SIC/NAICS _____ / _____ County _____

SIC NAICS

Owner/CEO _____ Type of Business _____

Phone _____ Email _____

Primary Contact _____ Title _____

Phone _____ Email _____

Secondary Contact _____ Title _____

Phone _____ Email _____

Program Details

Where will the **MASTER** copy be kept and made available to employees? (i.e., Corporate Headquarters, etc.) _____

Who is responsible for maintaining employee injury and illness records (OSHA 300 Logs)?

Name _____ Title _____ Phone _____

Who is responsible for maintaining employee medical and exposure records?

Name _____ Title _____ Phone _____

Where will employee medical and exposure records be kept? (i.e., Human Resources Department, etc.) _____

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Program Details (continued)

Where will results of Industrial Hygiene Monitoring be kept?
(i.e., Safety Coordinators Office, etc.)

Where will safety training records be kept? (i.e., Safety Coordinators Office, etc.)

Who is your Medical/Health Care Provider (i.e., medical clinic, physicians group, etc.)

Provider _____ **Phone** _____

Who is your Workers' Compensation Insurance Agency

Agency _____ **Phone** _____

Do you have a safety committee or group made up of management and labor representatives that meets regularly, and reports, in writing, on its activities? Yes No

Safety Officers

Enter the requested information for the designated Safety Officer responsible for administering the plans/programs listed below. If unknown, please write TBD. If not needed, please right N/A.

Safety Officers	Name & Job Title	Phone
Safety Coordinator		
Emergency Coordinator		
Fire Safety Officer		
Hazard Communication Officer		
Lockout/Tagout Officer		
Biosafety Officer		
Respiratory Protection Officer		
Hearing Conservation Officer		
Confined Space Officer		
Other (Please Specify)		

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Emergency Coordinator(s) (continued)

4. **Name** _____ **Title** _____
Work # _____ **Ext.** _____ **Other #s** _____ / _____
Phone Phone Phone

5. **Name** _____ **Title** _____
Work # _____ **Ext.** _____ **Other #s** _____ / _____
Phone Phone Phone

Emergency Evacuation

What is the **Primary Signal** for notifying employees to evacuate (i.e., bell, horn, siren, public address system announcement, etc.)? _____

What is the **Secondary Signal** for notifying employees to evacuate? _____

In case of an emergency, where should employees gather after and evacuation of the premises so an official head count can be taken to ensure that all personnel are accounted for? _____

Have you prepared a map of your facility which contains both a primary and secondary exit route? Yes No

(If Yes, please include a copy of the map when you submit this form to ACS.)

Emergency Response

Is your corporate facility located within 3-4 minutes of emergency medical services? Yes No

If not, who is/are your **First Aid Providers** that will render first aid at the worksite (person must have a valid certificate in first-aid training and be readily available during the work day)?

Name _____ **Title** _____
Work # _____ **Ext.** _____ **Other #s** _____ / _____
Phone Phone Phone

Name _____ **Title** _____
Work # _____ **Ext.** _____ **Other #s** _____ / _____
Phone Phone Phone

Please provide the following information for **Emergency Responders** (refer to your local telephone book). Please enter the proper name and telephone number for the closest agency.

Local Police Department _____
Emergency Phone # _____ **Non-Emergency Phone #** _____

Local Fire Department _____
Emergency Phone # _____ **Non-Emergency Phone #** _____

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Emergency Response (continued)

Local Ambulance/First Aid _____

Emergency Phone # _____ **Non-Emergency Phone #** _____

Local Hospital / Medical Center _____

Emergency Phone # _____ **Non-Emergency Phone #** _____

Electric Power Company _____

Emergency Phone # _____ **Non-Emergency Phone #** _____

Other _____

Emergency Phone # _____ **Non-Emergency Phone #** _____

Emergency Equipment

Please provide information about available emergency equipment (i.e. safety data sheets, portable fire extinguishers, first aid kits, emergency showers and/or eyewash stations, fire suppression systems, spill response kits, stretchers, oxygen tanks, etc.):

Type of Equipment	Description	Location	Inspection Frequency
Portable Fire Extinguishers	<input type="checkbox"/> ABC <input type="checkbox"/> Carbon Dioxide <input type="checkbox"/> Other _____		<input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other _____
Fire Suppression/Sprinkler System	<input type="checkbox"/> Wet <input type="checkbox"/> Dry		<input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other _____
First Aid Kit(s)	<input type="checkbox"/> Portable <input type="checkbox"/> Mounted <input type="checkbox"/> Other _____		<input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other _____
Emergency Eyewash	<input type="checkbox"/> Bottles <input type="checkbox"/> Self-contained <input type="checkbox"/> Plumbed		<input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other _____
Emergency Shower	<input type="checkbox"/> Drench hose <input type="checkbox"/> Safety shower		<input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other _____
Bloodborne Pathogens Spill Response Kit			<input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other _____
Hazardous Materials Spill Response Kit	<input type="checkbox"/> Speedy Dry <input type="checkbox"/> Other _____		<input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other _____
			<input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other _____

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Portable Fire Extinguishers

What company do you use to perform the annual maintenance and servicing of your portable fire extinguishers?

Company _____ Phone _____

Hazardous Materials Contingency

Please provide the following information about hazardous waste operations at your facility:

Do you generate hazardous waste? Yes No

(If No, go to Section 3)

Who is in charge of hazardous waste management at your company?

Name _____ Phone _____

What category of generator are you?

Conditionally-Exempt Small Quantity Generator (CQG)

Small Quantity Generator (SQG) EPA ID # _____

Large Quantity Generator (LQG) EPA ID # _____

Do you need a Hazardous Materials Contingency Plan (*required for LQG's, recommended for SQG's, not required for CQG's*)? Yes No

(If No, go to Section 3)

How does your facility handle a **Minor Spill** (incidental) or leak of a hazardous material?

Trained Employee(s) Outside Spill Response Contractor

How does your facility handle a **Major Spill** or leak of a hazardous material?

Trained HAZWOPER Employees Outside Spill Response Contractor

Outside Spill Response Contractor _____

Emergency Phone # _____ Non-Emergency Phone # _____

3. Hazard Communication Program

Hazardous Chemicals

Are hazardous chemicals used and/or stored in the workplace? Yes No

When was your last chemical inventory conducted? Date: _____

Do you have a current inventory list of all hazardous chemicals used and/or stored in the workplace? Yes No

(If Yes, please include a copy of your List of Hazardous Chemicals when you submit this form to ACS.)

Safety Data Sheets (SDS)

Do you have a SDS for each chemical in the workplace? Yes No

Do chemical names on the current list of hazardous chemicals match SDS names? Yes No

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Safety Data Sheets (SDS) (continued)

SDS' must be readily accessible in the workplace. Archive SDS' should be kept separate from those for currently used products. Please provide the following:

Safety Data Sheets	Description <i>(i.e., 3-ring binder, electronic, etc.)</i>	Location
Master Files		
Archive Files		
Additional Copies (for employees at remote worksites)		

In-House Container Labeling

What type of in-house workplace labeling system do you use?

NFPA (National Fire Protection Association) 704 Diamond

Hazardous Material Information System (HMIS)

Other (briefly describe) _____

Note: The recently revised Hazard Communication Standard (HazCom 2012) allows employers to continue to use their current in-house container labeling system as long as the labels align with GHS classification criteria.

Emergency Planning and Community Right to Know (EPCRA)

Is your company covered by [EPCRA](#) requirements?

Yes No

(If No, skip to Section 4.)

Who completes the Tier I or Tier II Chemical Inventory Reports for your company?

Name _____

Phone _____

When was your last report submitted to the state?

Date: _____

(Please include a copy of your last report when you submit this form to ACS.)

4. Lockout/Tagout Program

Lockout/Tagout Hardware and Devices

Where will locks, keys, tags and other energy isolating devices for the Lockout/Tagout Program be kept (i.e. Maintenance Department, Lockout/Tagout Officer's Office)? _____

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Designated Authorized & Affected Personnel

Authorized Employees	Affected Employees	Other Employees
Individuals and/or job classifications that have the authority and responsibility to perform lockout operations:	Individuals and/or job classifications whose equipment may be locked/tagged out:	Individuals and/or job classifications whose work operations are or may be in an area where energy control procedures may be utilized:

Lockout/Tagout Procedures

Have you conducted a survey to develop a detailed list of all equipment and/or machinery with permanent connections to energy sources or equipment that stores energy. (The list should document the location of all energy sources and the location of energy shutoff for each piece of equipment.)

Yes No

(If Yes, please include a copy of your equipment list when you submit this form to ACS.)

Do you have written, machine-specific lockout/tagout procedures for machines or equipment being locked or tagged out?

Yes No

(If Yes, please include copies of your machine-specific lockout/tagout procedures when you submit this form to ACS.)

5. Bloodborne Pathogens Exposure Control Plan

Who is responsible for the clean-up of equipment and small blood spills after minor worker injury?

Do you have any other employees potentially exposed to infectious agents in bodily fluids? (This may include employees who clean-up vehicle interiors after vehicular accident, laboratory personnel engage in clinical tasks such as testing human blood samples, etc.)

Yes No

(If No, go to Section 6)

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Designated Affected Personnel

Job classifications at your facility in which <u>ALL EMPLOYEES</u> have occupational exposure to blood or other potentially infectious material	Department/Location
<i>(Example: Lab Technician)</i>	<i>(Example: Research Laboratory)</i>
Job classifications at your facility in which <u>SOME EMPLOYEES</u> have occupational exposure to blood or other potentially infectious material	Task/Procedure
<i>(Example: Housekeeping)</i>	<i>(Example: Handling Regulated Waste)</i>

Does anyone at your facility handle needles or syringes? Yes No

Does your facility produce or use research-laboratory-scale amounts of HIV or HBV? Yes No

Does your facility engage in industrial-scale, large-volume or high concentration production of HIV or HBV? Yes No

6. Respiratory Protection Program

Is respiratory protection worn by employees, either by policy or voluntarily?
 Yes , by policy
 Yes, voluntarily
 No *(If No, go to Section 7)*

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Exposure Monitoring

Have you conducted any exposure monitoring to determine whether exposures are above or below established limits? Yes No

Respirator Medical Evaluations

Please provide the following information for the physician or other licensed health care professional (PLHCP) who will perform the respirator medical evaluations:

Name _____ Phone _____

Required Use of Respirators

Area/Situation	Contaminant	Type of Respirator Used	Type of Filter/Cartridge

7. Hearing Conservation Program

Is hearing protection worn by employees, either by policy or voluntarily? Yes , by policy
 Yes, voluntarily
 No (*If No, go to Section 8*)

Exposure Monitoring

Have you conducted any exposure monitoring to determine whether noise exposures are above or below established limits? Yes No

High Noise Areas / Job Functions / Situations	Decibel Levels (dBA) if known

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8. Confined Space Entry Program

Permit Required Confined Spaces

Do you have any permit required confined spaces? Yes No

<u>Permit Required Confined Spaces</u>				
Name & Location	Hazardous Atmosphere	Engulfment Hazard	Converging Wall Hazard	Other Recognized Hazard
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Non-Permit Required Confined Spaces

Do you have any non-permit required confined spaces? Yes No

<u>Non-Permit Required Confined Spaces</u>		
Name & Location	Description	Entry Permitted
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Notes/Special Instructions

The following written plans/programs are being requested (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Construction Safety Program | <input type="checkbox"/> Respiratory Protection Program |
| <input type="checkbox"/> Emergency Action & Fire Prevention Plan | <input type="checkbox"/> Hearing Conservation Program |
| <input type="checkbox"/> Hazard Communication Program | <input type="checkbox"/> Confined Space Entry Program |
| <input type="checkbox"/> Lockout/Tagout Program | <input type="checkbox"/> Hazardous Materials Contingency Plan |
| <input type="checkbox"/> Bloodborne Pathogens Exposure Control Plan | |

Thank you for completing this information request form. Please email completed form (and supplemental documents requested throughout the form) as attachments to the address you received the form from. We will process your request promptly.

Should you have any questions, contact our Client Service Department at 610.755.0728 or 800.55.HELPS.