APPENDIX B

EMERGENCY LOCKOUT/TAGOUT (LO/TO) DEVICE(S) REMOVAL FORM

If a personal lockout/tagout (LO/TO) device(s) is to be removed from a locked out or tagged out machine(s) or equipment(s) and the authorized employee is not on site, this form is to be completed by the employee’s Supervisor.

Authorized Employee: ____________________________________

Department: ________________________________

Type of Device (Lock & Tag or Tag Only): ____________________________________

Device Location: ____________________________________

Check off items as completed.
___ 1. The Supervisor and Crew Leader or Lead Worker have agreed the removal is required.
   The potential consequences of operating the equipment, both to personnel and the equipment were considered in the decision.
___ 2. The Supervisor or his/her designee, has attempted to make contact with the authorized employee to have the LO/TO device(s) removed. Circle manner in which contact was attempted: telephone, pager, search of site, other (specify): __________________________
   ___ 2a. The employee was contacted but it was not practical for him/her to return to site. Reason: ____________________________________________
   ___ 2b. The employee could not be contacted.
___ 3. Every effort has been made to assure no one will be put in danger by removing or cutting off the LO/TO device. The decision to remove or cut the LO/TO device was made by the employee’s Supervisor or higher ranking member of the Department.
___ 4. The employee designated to remove or cut the LO/TO device, (print name) __________________________, has been appropriately trained in lockout and tagout procedures.

** IF ITEMS 1, 2, 3 & 4 HAVE BEEN CHECKED OFF, **
** THE LO/TO DEVICE(S) MAY BE REMOVED OR CUT OFF. **

Date & Time LO/TO Device(s) Removed:
NOTE: The authorized employee whose LO/TO device was removed shall be immediately notified by his/her Supervisor of the removal upon his/her return to work.

Signature: ____________________________________________________________
Authorized Employee                 Date

Signature: ____________________________________________________________
Authorized Employee’s Supervisor                        Date

A copy of this completed form shall be forwarded to the employee’s Department head and to the Safety and Workers’ Compensation Office for review and retention.

Signature: ____________________________________________________________
Authorized Employee’s Department Head                      Date

Signature: ____________________________________________________________
Safety Director                                             Date