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| PERMIT-SPACE ALTERNATIVE PROCEDURE CHECKLIST |
| **Location**  **Description of Space** ­­­  **Department Responsible**  **Description of Work to be Performed**  **Check List Is Valid From:**  **To:**  (Date/Time) (Date/Time) |

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| **PREPARATIONS** |
| **YES NO**  1. Has the size (volume) and configuration of the space been determined prior to entry? ( ) ( )  2.a. Have persons involved in entry operations received permit-space training? ( ) ( )  2.b. Has the certifier received permit-space training? ( ) ( )  3.a. What tasks are to be performed during the entry operation?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3.b. Is a hazardous atmosphere the only serious hazard of concern? ( ) ( )  **If no, alternative procedures cannot be used unless all other serious hazards are eliminated and documented using the re-classification checklist**.  4. Does the atmospheric hazard in the space have the potential to create high  Temperatures or high pressures? ( ) ( ) **If yes, take appropriate action before removing cover.**  5. Are conditions safe to remove cover? **If no, cover removal is prohibited)** ( ) ( )  6. After cover removal, is opening properly guarded? ( ) ( )  **YES NO**  7.a. Will continuous forced air ventilation be provided? ( ) ( )  If no, explain why:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  7.b. If yes, explain capacity (CFM) air exchange rate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cfm  Minimum ventilation duration prior to allowing entry\_\_\_\_\_\_\_\_\_\_\_\_ cfm  (Conduct pre-entry atmospheric testing and continue to ventilate the space during the entire entry operation)  8. Is atmospheric testing equipment calibrated? Date of calibration: ( ) ( )  9. Does inspection of interior have to be conducted to see if serious hazards exist? ( ) ( )  (**If yes, full entry program is required**)  10.a. Will frequent or periodic atmospheric testing be performed? ( ) ( )  10.b. Who is to perform frequent or periodic testing?  11. If a hazardous atmosphere is detected during entry, have all persons involved in ( ) ( )  Entry operations been instructed to evacuate the space immediately.  (If no, instruct employees of this safety precaution measure and the need to prohibit re-entry back into this space using alternative procedures until the space has been re-evaluated by authorized and qualified personnel.)  12. Specify any personal protective equipment or additional precautions necessary to ensure the safety of entrant(s):    **COMPLETE BACK PAGE** |
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| **ATMOSPHERIC TESTING** | | | | | | | | | | | | |
| N/A=Not Applicable REQ=Required COM=Completed | | | | | | | | | | |
| **N/A REQ** **N/A REQ** | | | | | | | | | | |
| **( ) ( ) Continuous Monitoring ( ) ( ) Periodic Monitoring** | | | | | | | | | | |
| **N/A REQ COM *Allowable Limits* Time: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_** | | | | | | | | | | |
| ( ) | ( ) | ( ) |  | Oxygen Level | 19.5%-23.5% |  | % | % | % | % |
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| ( ) | ( ) | ( ) |  | Flammability | 10% LEL (CH4) |  | % | % | % | % |
|  |  |  |  |
| ( ) | ( ) | ( ) |  | Hydrogen Sulfide | 10 PPM |  | ppm | ppm | ppm | ppm |
|  |  |  |  |
| ( ) | ( ) | ( ) |  | Carbon Monoxide | 35 PPM |  | ppm | ppm | ppm | ppm |
|  |  |  |  |
| ( ) | ( ) | ( ) |  | Toxic: Specify: \_\_\_\_\_\_\_\_\_\_\_ | |  | ppm | ppm | ppm | ppm |
|  |  |  |  |
| ( ) | ( ) | ( ) |  | Temperature    are available) | |  | F | F | F | F |
|  |  |  |  |
|  |  |  |  |  | |  |  |  |  |  |
| Name/Dept of Employee(s) Conducting Testing (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |

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Signature of Certifying Individual Date