

EMERGENCY LOCK REMOVAL FORM

This form must be completed prior to the employee's lock being removed.

Name of employee who applied lock:

I.D.#

Job Title:

Dept.

Type of energy isolation used:

Date applied:

Reason for Lockout/Blockout

Reason for emergency lock removal:

Describe all reasonable attempts to contact employee:

Certification that employee could not be located:

Supervisor's name:

Date & time:

Review of equipment/machine/process to ensure safe Lockout/Blockout device removal.

No employee exposures _____

No electrical exposures _____

Guards in place _____

No open pipe exposures _____

Review conducted by: _____

Authorized employee

Job title

Date & time

Certification that authorization was received before the employee's Lockout/Blockout device was removed:

Department Manager

Date & time

| | | |
|--------------------------------------------------------------------|--------|-------|
| Employee authorized to remove Lockout/Blockout device: | | |
| Was the employee contacted prior to resuming work at the facility? | | |
| Employee statement concerning failure to remove device: | | |
| Employee's signature: | | |
| Supervisory action to prevent recurrence: | | |
| Form completed by: | | |
| Name: | Title: | Date: |
| Reviewed by: | | |
| Name: | Title: | Date: |