

APPENDIX N-5 TASK SPECIFIC EXPOSURE CONTROL PLAN

| | | | |
|---|--|--|---|
| DATE CONTROL PLAN COMPLETED: | | | |
| PRIME CONTRACTOR: | | SUPERINTENDENT: | |
| PROJECT MANAGER: | | CSO/FA: | |
| PROJECT: | | ADDRESS: | |
| COMPANY COMPLETING WORK: | | | |
| ADDRESS: | | CONTACT: | |
| CONTACT PHONE: | | CONTACT FAX: | |
| ONSITE SUPERVISOR(S): | | | |
| WORKER(S): | | | |
| | | | |
| | | | |
| SCOPE OF WORK TO BE COMPLETED: | | | |
| WORK START DATE: | | DURATION: <input type="checkbox"/> DAYS <input type="checkbox"/> MONTHS <input type="checkbox"/> YEARS | |
| EMPLOYER RESPONSIBLE FOR: | | | |
| SUPERVISOR RESPONSIBLE FOR: | | | |
| WORKER RESPONSIBLE FOR: | | | |
| HAZARDS IDENTIFIED (Other than silica dust) | | CONTROL MEASURE(S) | |
| <input type="checkbox"/> FALLS | | | |
| <input type="checkbox"/> SLIPPING | | | |
| <input type="checkbox"/> CONFINED SPACE | | | |
| <input type="checkbox"/> WORKERS ABOVE | | | |
| <input type="checkbox"/> WORKERS BELOW | | | |
| <input type="checkbox"/> NOISE | | | |
| <input type="checkbox"/> ELECTRICAL | | | |
| OVERVIEW OF WORK PROCEDURE (How are you going to work safely?): | | | |
| WORKERS TRAINED IN (Training records must be available for review): | | | |
| PROPER USE OF GRINDING EQUIPMENT | Y <input type="checkbox"/> N <input type="checkbox"/> | PROPER USE OF ADMIN CONTROLS | Y <input type="checkbox"/> N <input type="checkbox"/> |
| PROPER USE OF ENGINEERING CONTROLS | Y <input type="checkbox"/> N <input type="checkbox"/> | PROPER USE OF PPE | Y <input type="checkbox"/> N <input type="checkbox"/> |
| PROPER DISPOSAL METHODS | Y <input type="checkbox"/> N <input type="checkbox"/> | Other (Fall Protection, Swing Stages, etc) | Y <input type="checkbox"/> N <input type="checkbox"/> |
| RESPIRATORS (Refer to ECP for respirator requirements) | | | |
| REQUIRED: Y <input type="checkbox"/> N <input type="checkbox"/> | AVAILABLE: Y <input type="checkbox"/> N <input type="checkbox"/> | FIT TESTED: Y <input type="checkbox"/> N <input type="checkbox"/> | |
| PPE REQUIRED FOR SCOPE OF WORK (Other than respirator) | | | |
| <input type="checkbox"/> COVERALLS <input type="checkbox"/> GLOVES <input type="checkbox"/> RUBBER BOOTS <input type="checkbox"/> EYE PROTECTION <input type="checkbox"/> REFLECTIVE VEST <input type="checkbox"/> HEARING PROTECTION | | | |

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WASTE PROPERLY DISPOSED OF Y N

TABLE 1 (Codes for task/risk management matrix)

| ENGINEERING CONTROLS | | ADMINISTRATIVE CONTROLS | | PPE | | SUPPLIES/EQUIPMENT | |
|----------------------|-------------------|-------------------------|------------------|-----|--------------------|--------------------|--------------------------|
| 1 | Exhaust Fan | 1 | Signage | 1 | Respirator | 1 | Hand Grinder |
| 2 | LEV | 2 | After Hours Work | 2 | Gloves | 2 | Ceiling Grinder |
| 3 | Wetting | 3 | Scheduling | 3 | Coveralls | 3 | Floor Grinder |
| 4 | Partial Enclosure | | | 4 | Hearing Protection | 4 | Disposal Bags |
| 5 | Full Enclosure | | | 5 | Eye Protection | 5 | HEPA filter (Vacuum) |
| 6 | Shroud | | | 6 | Reflective Vest | 6 | HEPA filter (Respirator) |
| 7 | Barriers | | | 7 | Rubber Boots (CSA) | 7 | Shovel |
| | | | | 8 | Fall Arrest | 8 | Life Line |
| | | | | | | 9 | Roller and pan |
| | | | | | | 10 | Brush / trowel |

SITE SPECIFIC EXPOSURE CONTROL PLAN

Location: _____ Date: _____

Work Description:

PRIMARY HAZARD CONTROL OPTIONS (Check those options used and explain use if needed):

◆ **SUBSTITUTIONS CONTROLS:** (Using procedures or products that do not create hazard, must review MSDS's)

Other means of work: _____

Different products: _____

Other substitutions: _____

◆ **ENGINEERING CONTROLS:** (When using ventilation draw air out & don't expose others to exhaust hazards)

Vacuuming: _____

Wetting: _____

Ventilation: _____

Isolation: _____

Other means: _____

◆ **ADMINISTRATION CONTROLS:** (Reducing exposure by work schedules, timing or planning options)

Control points: _____

Work schedule: _____

Other means: _____

SECONDARY CONTROL OPTIONS (Check those options used and explain use if needed):

◆ **PERSONAL PROTECTIVE EQUIPMENT:**

½ Mask respirators: _____ Cartridge type: _____ Fit tests confirmed: _____

Full face respirators: _____ Cartridge type: _____ Fit tests confirmed: _____

Supplied air units: _____

Coveralls required: _____

◆ **HYGIENE & DECONTAMINATION OPTIONS** (Reducing exposures after work has stopped or during breaks)

Water or washing facilities on site: _____

Vacuuming clothing / self: _____

SAFE WORK PROCEDURES & OTHER DETAILS: _____

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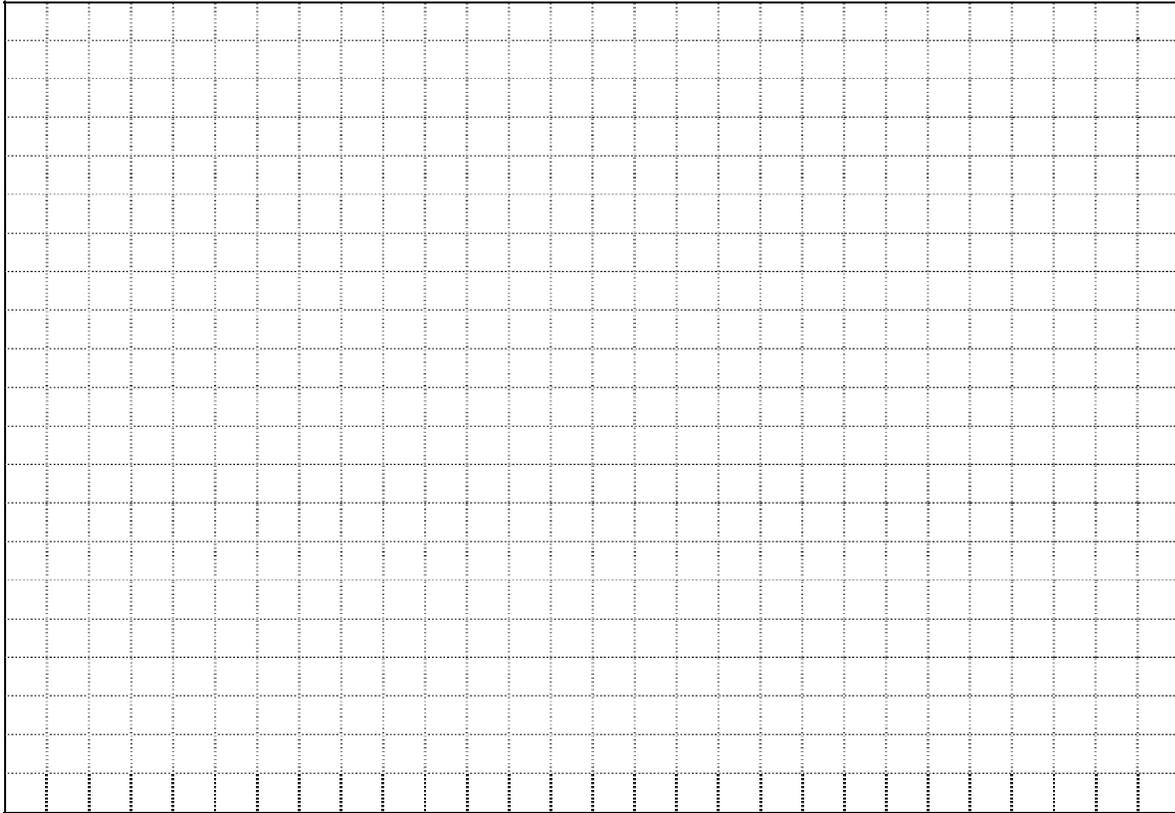
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Ventilation Plan (sketch)



← Show direction of airflow including makeup air locations and discharge air outlets

Area or Location in Building of Ventilation Plan (eg. floor #, wing)

Date plan was reviewed by workers and posted for workers to see

Types of Neg. Air Fans & No.'s *

* Indicate on Plan by No. the location of the Negative Air Fans

Ventilation Safety Check List

- | | |
|--|--|
| <input type="checkbox"/> Make-up air free of possible contaminants | <input type="checkbox"/> Workers not placed between contaminants created and exhaust inlet ports |
| <input type="checkbox"/> Exhaust fan operation has failure warning | <input type="checkbox"/> Discharge air not affecting others |
| <input type="checkbox"/> Dilution fans not stirring up dusts | <input type="checkbox"/> All workers equipped with approved respirators |
| <input type="checkbox"/> Wetting of materials used to keep dust down | |

Note: Attach additional sheets if needed or other documents if required due to hazards or work conditions

Print Supervisors Name

Supervisors Signature