



TOOL BOX SAFETY MEETING

Name of Person Conducting Meeting:	
Job Number:	Date:
Job Site:	Location:

Topics

SAFETY INSPECTION CHECKLIST

Location:	Time of Audit:	AM	PM
Date:	Supervisor:		
Unit:			
Equipment:			

Permitting	Y	N	Comments / Corrective Action Taken
1. Does the permit reflect the right date?			
2. What type of permit is written?			
3. Does the permit give a direct description of what the task is?			
4. Is the permit signed off authorizing task start-up?			
5. Do the employees have a general knowledge of what the permit states?			
6. Are employees in compliance of the permit?			

Personal Protective Equipment	Y	N	Comments / Corrective Action Taken
1. Are employees complying with all the PPE as listed on the permit?			
2. Are employees using all PPE as required by Company policy?			
3. Are employees wearing hard hats, safety glasses, ear plugs, and gloves?			
4. H ₂ S monitors being used and are they being worn correctly?			
5. Are proper safety glasses being worn? (Dark/Clear)			
6. Is fall protection required?			
7. Is fall protection being worn right?			
8. Are employees practicing 100% tie off policy?			
9. Are employees tied off to a sufficient anchorage point?			
10. Are employees tied off above their head to minimize fall?			
11. Do employees show a general knowledge of what PPE to use and why it is being used? (Please ask the employee)			
12. Are respirators required?			
13. Are employees using the right type of respirator for the task assigned? (Half-Mask, Full Face dual cartridge, Airline, Sams)			
14. Have employees been trained in the proper use, care, storage and maintenance of the respirators?			

SAFETY INSPECTION CHECKLIST

Equipment	Y	N	Comments / Corrective Action Taken			
1. Are forklifts being used?						
2. Have all forklifts been inspected?						
3. Are operators trained?						
4. Do operators have their training cards readily available?						
5. Are speed limits being followed?						
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Confined Space and Dumping	Y	N	Comments / Corrective Action Taken			
1. Is the entry an inert entry?						
2. Are all outlets / inlets blinded / isolated?						
3. Is retrieval devices in place and functioning correctly?						
4. Has a confined space permit been issued?						
5. Is the temperature below 100 degrees Fahrenheit?						
6. Is the LEL below 10ppm?						
7. Is a rescue plan in place?						
8. Are the top Supv. & the bottom Supv. available?						
9. Are communications established and functioning correctly?						
10. If inert conditions are present, are other employees set up as to not be down wind from escaping nitrogen?						
11. Are all documents in place and being filled out?						
12. Are employees wearing Proper PPE?						
13. Is vec loader being used?						
14. Is the vec loader grounded?						
15. Are all hoses to the loader secured?						
16. Are fire extinguishers readily available?						
17. What are the readings on the monitor at time of inspection?	O ₂		LEL	Temp	Comb	

SAFETY INSPECTION CHECKLIST

Scaffolds	Y	N	Comments / Corrective Action Taken
1. Scaffolds been inspected per shift?			
2. Scaffolds properly constructed for load?			
3. Access ladders 3 ft. above deck?			
4. Guardrails, toe boards, decking in place?			

Electrical	Y	N	Comments / Corrective Action Taken
1. GFCIs being used?			
2. All cords inspected and properly color coded?			

Slings / Chokers	Y	N	Comments / Corrective Action Taken
1. Slings / Chokers free of cracks, tears, rips, or defects?			
2. Have shackles / hooks been inspected and free from defects?			

Other Comments / Corrective Actions and Positive Feedback

# Of Items Audited	# Of Items Answered Deficient	% Compliance on this Audit

Auditor (print)	Auditor (signature)
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SHIFT NOTES

Date: _____ Job Number: _____
Client: _____ Reactor: _____

Shift:	Morning	Afternoon	Evening	Night Shift	Day Shift
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Weather and Environmental Conditions

Temperature:	Wind Direction:	Wind Speed:	Humidity:
Heat Index:	Wind Chill Factor:	Precipitation:	Dew Point:
Topography Considerations:			(Sumps, Drains, Berms, etc.)
Data Collected From:			

Key Activities:

Brief description of key activities conducted during the shift. Include additional activities or tasks completed.

Incidents/Concerns:

Briefly describe any incidents or concerns noted during the shift. Please include the actions taken or recommended.

Equipment Status:

Briefly describe the status of key equipment or machinery used during the shift. Please include any issues or maintenance needs.

Upcoming Tasks/Events:

Tasks or events scheduled for the next shift or upcoming days

Prepared by:



SHIFT NOTES

Date: _____

Job Number: _____

Client: _____

Reactor: _____

TIME 24hr

ADDITIONAL NOTES:

[illegible]

BBSO / IDEA REPORT / LMRA FEEDBACK

Reported By: _____	Score: _____
Site Location: _____	
Date (mm/dd/yy): _____	
Observation / Idea / Feedback Location: _____	

Brief Description of Observation / Idea / Feedback:

Worker Observer Action:	
Controlled (Eliminated Isolated, Minimized)	LMRA (Beginning and Throughout Task)

Additional Notes:

ITCS Representative

Client Representative

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Additional Notes:

ITCS Representative

Client Representative