

FairPoint Communications, Inc.

Forms Appendix

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FairPoint Communications, Inc.
First Report of Occupational Injury & Illness

Company: _____ Location #: _____

Injured or Ill Employee

Name of Employee: _____ Payroll No: _____
Normal Assignment: Department _____ Job Title: _____

Injury or Illness

Briefly describe the nature and degree of the injury or illness as claimed by the employee and observed by you: _____

Where was the employee sent for treatment: _____

Did employee return during shift: Yes [] No [] If yes, was employee returned to normal assignment and able to perform all significant duties: Yes [] No [] If no, describe transfer or work limitation.

Reporting of Incident

Time of incident as stated by employee: Date: _____ Time: _____ Unknown: _____

Did employee report incident to you: Yes [] No [] If yes: Date: _____ Time: _____

If initially reported to others: To whom: _____ Date: _____ Time: _____

Description of Incident (as reported by employee)

Where did incident occur (be exact): _____

What was employee doing or attempting to do at the time: _____

What happened: _____

Why did it happen: _____

City and State: _____

Verification of Report

Were there witnesses: Yes [] No []

Do the witnesses confirm the employee's story: Yes [] No [] If no, explain the discrepancies:

Are you convinced the injury or illness is work related: Yes [] No [] Not sure [] If no or not sure, explain: _____

Signature

Supervisor: Name _____ Date: _____

Title _____ Time: _____

Human Resources: Name: _____

Title: _____

Date Received: _____

Date Reported: _____



FairPoint Communications, Inc.

Incident Investigation & Analysis Report

Employee: Company:			Type of Incident:			
Sex: <input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Striking against	<input type="checkbox"/> Contact with sharp object		
			<input type="checkbox"/> Caught in between	<input type="checkbox"/> Exposure to heat or cold		
			<input type="checkbox"/> Fall on same level	<input type="checkbox"/> Exposure to toxic material		
			<input type="checkbox"/> Fall to different level	<input type="checkbox"/> Fire or explosion		
			<input type="checkbox"/> Vehicle collision	<input type="checkbox"/> Other		
			<input type="checkbox"/> Lifting or overexertion			
Age Group <input type="checkbox"/> Under 21 <input type="checkbox"/> 21 – 34 <input type="checkbox"/> 35 – 40 <input type="checkbox"/> Over 50	Length of Service <input type="checkbox"/> < 1 year <input type="checkbox"/> 1-5 years. <input type="checkbox"/> 5-10 years <input type="checkbox"/> Over 10 years	Type Employment <input type="checkbox"/> Outside Plant <input type="checkbox"/> Inside Plant <input type="checkbox"/> Maintenance <input type="checkbox"/> Admin & Sales				
Type(s) of Injury or Illness:			Parts of Body Affected:			
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Fracture or Break	<input type="checkbox"/> Skin Disease	Head	Trunk	Arm	Leg
<input type="checkbox"/> Contusion	<input type="checkbox"/> Burn-Thermal	<input type="checkbox"/> Respiratory Illness	<input type="checkbox"/> Face	<input type="checkbox"/> Chest	<input type="checkbox"/> Upper	<input type="checkbox"/> Thigh
<input type="checkbox"/> Laceration (cut)	<input type="checkbox"/> Burn-Chemical	<input type="checkbox"/> Systemic Poisoning	<input type="checkbox"/> Skull	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Elbow	<input type="checkbox"/> Knee
<input type="checkbox"/> Puncture Wound	<input type="checkbox"/> Hernia	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Lower	<input type="checkbox"/> Lower
<input type="checkbox"/> Strain (muscle)	<input type="checkbox"/> Concussion	<input type="checkbox"/> Amputation	<input type="checkbox"/> Eye	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Wrist	<input type="checkbox"/> Ankle
<input type="checkbox"/> Sprain (joint)	<input type="checkbox"/> Fatality		<input type="checkbox"/> Ear	<input type="checkbox"/> Hip	<input type="checkbox"/> Hand	<input type="checkbox"/> Foot
<input type="checkbox"/> Other			<input type="checkbox"/> Finger			<input type="checkbox"/> Toe
			<input type="checkbox"/> Other			

Description of Illness or Injury: _____

Description of Incident (as revealed by investigation)
 Give detailed story of incident:

Causes of Incident (This MUST be completed!)
 Did any PHYSICAL CONDITIONS contribute to the occurrence: Yes No If yes, list and describe the conditions: _____

How and why were conditions created:

Did any ACT by the employee or others contribute to the occurrence: Yes [] No [] If yes, list and describe the acts: _____

Why were the acts committed: _____

Was a safety policy violated: Yes [] No [] What policy(s): _____

Prevention of Future Incidents

What actions are necessary to prevent this type of incident from happening again:

Immediate Action Taken:

Items requiring further action (describe):

Referred to for action:

Signatures

Incident Investigator: _____ Date _____

Plant Manager: _____ Date _____

Safety Committee Chairperson: _____ Date _____

Loss Summary (complete later when claim is closed)

Days lost: Away from Work _____ WC loss: Medical \$ _____

Basic Cause(s):

- Faulty Design/Layout
- Faulty Construction
- Faulty Maintenance
- Faulty Operational Method
- Faulty Direct Supervision
- Faulty Job Training

Human Factors:

- Personal Limitation
- Failure to Work Defensively
- Lack of Experience
- Unknown
- Unavoidable

VEHICLE ACCIDENT DETERMINATION

PREVENTABLE

NON-PREVENTABLE

COMMENTS

Accident Review Board

Risk Management

Name

Signature

Date

Safety Manager

Name

Signature

Date

Safety Council Member

Name

Signature

Date

Operations/Engineering

Name

Signature

Date



DRIVER'S REPORT OF ACCIDENT

COMPANY DRIVER NAME: _____ PHONE: _____

SUPERVISOR NAME: _____ PHONE: _____

COMPANY PASSENGERS: _____

ACCIDENT INFORMATION

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____

ACCIDENT SITE (City & State): _____

DESCRIPTION OF ACCIDENT (including physical injuries & damage to vehicles):

COMPANY VEHICLE INFORMATION:

YEAR: _____ MAKE/MODEL: _____ VIN: _____

PLATE NO.: _____ STATE: _____ COLOR: _____

OTHER VEHICLE INFORMATION:

YEAR: _____ MAKE/MODEL: _____ VIN: _____

PLATE NO.: _____ STATE: _____ COLOR: _____

DRIVER LICENSE NO.: _____ STATE: _____

Name, Address & Phone Number of DRIVER: _____

Name, Address & Phone Number of OWNER of other vehicle: _____

Name and Policy Number of other party's insurance carrier : _____

POLICE INVESTIGATION:

Were police notified? YES NO If YES, which agency responded? _____

Officer's Name & Badge No.: _____ Anyone Cited? NO YOU OTHER DRIVER

Any INJURIES to Company Employees? YES NO

Any INJURIES to Other Parties? YES NO

Describe DAMAGE to Company Vehicle: _____

Describe DAMAGE to Other Vehicle: _____

INJURED PERSONS

(1) Name, Address and Phone Number of INJURED PERSON? _____

INJURED WAS? DRIVER PASSENGER IN OTHER VEHICLE PEDESTRIAN

DESCRIPTION OF INJURY: _____

(2) Name, Address and Phone Number of INJURED PERSON? _____

INJURED WAS? DRIVER PASSENGER IN OTHER VEHICLE PEDESTRIAN

DESCRIPTION OF INJURY: _____

(3) Name, Address and Phone Number of INJURED PERSON? _____

INJURED WAS? DRIVER PASSENGER IN OTHER VEHICLE PEDESTRIAN

DESCRIPTION OF INJURY: _____

WITNESSES

(1) Name, Address and Phone Number of WITNESS? _____

(2) Name, Address and Phone Number of WITNESS? _____

(3) Name, Address and Phone Number of WITNESS? _____

OTHER COMMENTS

EMPLOYEE SIGNATURE: _____

DATE OF REPORT: _____



GENERAL LIABILITY LOSS NOTICE

NON-EMPLOYEE INJURY/PROPERTY DAMAGE CLAIMS AGAINST THE COMPANY/ACTUAL OR ALLEGED
(ACCIDENTS NOT INVOLVING COMPANY VEHICLES)

Complete sections 1,4, 5 and 9 in all cases. Complete other sections as applicable

COMPANY	ADDRESS	POLICY #/LOCATION # /
---------	---------	--------------------------

1. ACCIDENT DATA

ACCIDENT DATE	HOUR <input type="checkbox"/> AM <input type="checkbox"/> PM	EXCHANGE	DEPARTMENT
LOCATION OF ACCIDENT (NUMBER AND STREET)		CITY	STATE
			IS COMPANY OWNER OF PREMISES <input type="checkbox"/> YES <input type="checkbox"/> NO IF "NO" EXPLAIN
POLICE INVESTIGATION? <input type="checkbox"/> LOCAL <input type="checkbox"/> STATE <input type="checkbox"/> COUNTY <input type="checkbox"/> NONE		AGENCY NAME	REPORT NO.

2. PROPERTY DAMAGE

Also complete Section 7 or 8 for subsurface or aerial related damage

OWNER OF DAMAGED PROPERTY	TELEPHONE NO.		
OWNER'S ADDRESS (NUMBER AND STREET)	CITY	STATE	ZIP CODE
DESCRIBE PROPERTY DAMAGED (MAKE, MODEL, AGE, ETC.) AND EXTENT OF DAMAGE			
WHERE CAN DAMAGED PROPERTY BE SEEN?	EST. COST OF REPAIR OR REPLACEMENT. ATTACH EST. IF AVAILABLE \$		
DATE COMPANY NOTIFIED OWNER OF DAMAGE	TIME NOTIFIED <input type="checkbox"/> AM <input type="checkbox"/> PM	NAME OF PERSON NOTIFIED	

3. INJURED PERSON

NAME OF INJURED PERSON	BIRTH DATE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	OCCUPATION
INJURED PERSON'S ADDRESS (NUMBER AND STREET)		CITY	STATE
			ZIP CODE
TELEPHONE NO. OF INJURED PERSON		<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	OCCUPATION
EMPLOYED BY (EMPLOYER'S NAME AND ADDRESS)			
PARENT OR GUARDIAN'S NAME AND ADDRESS (IF INJURED IS A MINOR)			
NATURE AND EXTENT OF INJURY			
WHERE WAS THE INJURED TAKEN?			
NAME OF DOCTOR	ADDRESS	TELEPHONE NO.	
WHY WAS PERSON AT PLACE OF ACCIDENT? WHAT WAS PERSON DOING?			
STATEMENT OF INJURED PERSON			

PLEASE COMPLETE THE 2ND AND 3RD PAGE – ATTACH ADDITIONAL FORM IF NEEDED
CONFIDENTIAL REPORT TO COMPANY ATTORNEYS

FairPoint Communications, Inc. General Liability Loss Notice

4. ACCIDENT DESCRIPTION

DESCRIBE WHAT HAPPENED AND HOW IT HAPPENED. PROVIDE PHOTOGRAPHS AND SKETCH IF USEFUL FOR CLARIFICATION

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5. WITNESSES

(INDICATE "E" IF AN EMPLOYEE)

NAME	ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO. ()
					()
					()
					()
					()

6. COMPANY CONTRACTOR ACCIDENTS

NAME OF CONTRACTOR	NAME OF CONTRACTOR SUPERVISOR		
WORK ORDER NO.	NAME OF COMPANY	TELEPHONE NO. ()	
HAVE YOU COMMUNICATED WITH THE CONTRACTOR REGARDING THIS OCCURRENCE? () YES () NO			NAME OF PERSON CONTACTED
PRESENT STATUS			

7. SUPPLEMENTAL INFORMATION – SUBSURFACE FACILITY DAMAGE

DID COMPANY REQUEST ADVANCE LOCATION? () YES () NO	DATE OF REQUEST	REQUEST NO.	STATE ACCURACY OF LOCATE: WITHIN INCHES OF ACTUAL FACILITY	COVER AT POINT OF DAMAGE () INCHES () FEET
INDICATE METHOD OF MARKING () STAKED () PAINTED () OTHER	DID COMPANY POTHOLE OR HAND DIG TO LOCATE?		ESCAVATION PERMIT OBTAINED? () YES () NO () NA	LOCATION OF FACILITY () WITHIN STREET RIGHT-OF-WAY () PRIVATE PROPERTY () COMPANY/UTILITY EASEMENT
DESCRIBE WORK BEING PERFORMED				
TYPE OF EQUIPMENT CAUSING DAMAGE				
LAST DAY WORKED AT THIS SITE IF EVIDENCE IS CIRCUMSTANTIAL. ATTACH SKETCH SHOWING PROXIMITY OF TELEPHONE STRUCTURE TO DAMAGED FACILITY				

FairPoint Communications, Inc. General Liability Loss Notice

8. SUPPLEMENTAL INFORMATION – DAMAGE INVOLVING AERIAL FACILITIES

PLEASE COMPLETE IF CLAIM INVOLVES DAMAGE RESULTING FROM A VEHICLE CONTACTING AERIAL LINES			
DRIVER'S NAME AND ADDRESS	TELEPHONE NO. ()	VEHICLE LICENSE NO. & STATE	VEHICLE YEAR
OWNER'S NAME AND ADDRESS	TELEPHONE NO. ()	MAKE	BODY STYLE
MEASURED HEIGHT OF VEHICLE (HIGHEST POINT, OR POINT OF CONTACT, IF VISIBLE)		NAME OF PERSON WHO MEASURED VEHICLE	TELEPHONE NO. ()
ESTIMATE OF COMPANY CLEARANCE PRIOR TO OCCURRENCE AND HOW DETERMINED. ATTACH SKETCH SHOWING PLANT CONFIGURATION, GRADE AND CLEARANCE			
DESCRIBE ANY CONDITIONS WHICH HAVE ALTERED CLEARANCE (i.e.. NEW DRIVEWAY UNDER POLE LEAD, NO NOTIFICATION TO COMPANY)			JOINT POLE INVOLVED ()YES ()NO

9. GENERAL INFORMATION

EMPLOYEE NAME (FIRST, MI, LAST)	SOCIAL SECURITY NO.	JOB TITLE	TELEPHONE NO. ()
WORK ORDER NO. OR JOB BEING WORKED		DATE ACCIDENT REPORTED TO COMPANY	
DATE OF INVESTIGATION	BY WHOM?	TELEPHONE NO. ()	
NAME AND SIGNATURE OF PERSON PREPARING REPORTA	TITLE	TELEPHONE NO. ()	
COMPANY MAILING ADDRESS (MC, RC, etc.)	DATE	CLAIM SETTLED BY: () LOCAL OFFICE () CLAIM CENTER	



PROPERTY LOSS NOTICE

COMPANY: _____ POLICY/LOCATION: _____ / _____

CONTACT: _____ PHONE: _____

DATE OF LOSS: _____ TIME OF LOSS: _____

LOCATION OF LOSS: _____

DESCRIBE CAUSE OF LOSS: _____

DESCRIBE THE NATURE OF ANY PROPERTY DAMAGE SUSTAINED:

WEATHER CONDITION: _____

WERE PICTURES TAKEN, IF SO BY WHOM: _____

IDENTIFY ANY AUTHORITIES CALLED TO THE SCENE (Fire, Police, Medical):

WAS A REPORT FILED: _____ (Please send a copy as soon as possible)

IDENTIFY ANY WITNESS(ES) TO THE INCIDENT:

Name: _____

Address: _____

Telephone: _____



FairPoint Communications, Inc.
Confined Space Entry Permit

Company: _____ Location: _____

Date and Time _____ Project Name: _____

Permit Expiration Time: _____

Permit Space Location and Description: _____

Purpose of Entry: _____

Pre-Entry Checklist

NOTE: The entire form must be completed prior to confined space entry.

1.	Atmospheric testing: To be conducted in the following order.			
A.	Order	Substance	Acceptable Level	Readings Acceptable
	1.	Oxygen (O ₂)	19.5% - 23.5%	Yes No
	2.	Explosive Gas or Vapor	<10% LFL	Yes No
	3.	Explosive Dust	<LFL (5 ft visibility)	Yes No
	4.	Carbon Monoxide	50 ppm	Yes No
	5.	Hydrogen Monoxide	<10 ppm	Yes No
	6.	Other		Yes No
	7.	Other		Yes No
B.	Continuous forced air ventilation in place where required?			NA Yes No
C.	Are explosion-proof tools and equipment required?			NA Yes No
D.	Is a 20 lb. ABC extinguisher present where required?			NA Yes No
2.	Control of Hazardous Energy			
A.	Are all lines to vessel locked out – broken – capped – or blanked?			NA Yes No
B.	Are all switches and valves locked or tagged out?			NA Yes No
C.	Is all mechanical equipment locked out or tagged to prevent accidental startup?			NA Yes No
3.	Is opening to confined space adequately protected?			NA Yes No
4.	Is a means of communication established between entrant and attendant?			NA Yes No
5.	Is entrant equipped with appropriate personal protective equipment?			NA Yes No
6.	Is each entrant equipped with a harness and lifeline for emergency rescue operations?			NA Yes No
7.	Are the names and numbers of emergency rescue services readily available?			NA Yes No
8.	Is an adequate lighting source, safe for conditions in the space, provided?			NA Yes No
9.	Will welding operations be performed within the space? (If "yes", a Confined Space Hot Work Permit must be completed).			NA Yes No
10.	Have all personnel received the appropriate training for their duties?			NA Yes No

IF NO IS MARKED FOR ANY ITEM, ENTRY OPERATIONS MAY NOT PROCEED.

Superintendent Entry Authorization: _____

Signature of Attendant: _____

Signature of Entrants: _____

FairPoint Communications, Inc. Hazard Assessment Survey, Part II

Company: _____ Location: _____

Area/Shop/Location: _____

Fill out this form once for each body area affected. For each HAZARD checked Yes on page 1, place an X in the basic hazard box for the body area affected. Answer the questions below. Include a review of any injury data for problem areas.

	Impact	Penetration	Com- pression	Chemical	Heat/ Cold	Harmful Dust	Light Radiation	Other
Body Area Affected (i.e. Eye/Face, Head):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe the possible injuries (only to body area specified above).

Skip the next 2 questions if you decide PPE is necessary and PPE selected will protect workers from hazard.

Describe the possible risk for EACH hazard checked.

Determine and describe the seriousness of potential worker injury for EACH hazard.

When multiple hazards exist, are combinations of PPE needed or used? Explain.

List the PPE selected.

Discuss any "Other" issues.

Evaluation Performed By: _____
Print Name
Signature

Evaluation Date: _____

FairPoint Communications, Inc.
Instructions to Complete Hazardous Materials List

1. List alphabetically the name of the chemicals you use in your area.
2. The name of the chemical must appear as it does on the MSDS.
3. Submit this completed list to the appropriate manager at your location and each time you update the list.
4. UPDATE this list when a:
 - a. New chemical is introduced
 - b. Substitute chemical is introduced
 - c. Chemical is no longer used

Keep old list! Document when you update lists. Keep old lists in a separate file.



FairPoint Communications, Inc.

Personal Protective Equipment Hazard Assessment

Company: _____ Location: _____
 Job Position or Task _____ Date: _____
 Department: _____

Brief Description of Job: (Tasks Involved)

Head & Face ANSI Z89.1 1986

Any potential of struck by, falling objects, flying objects or projectiles, chemical spills, splashes, noise, molten metals, acids or caustic liquids, chemical gases or vapors, dusts, harmful lights?

Hazards	Suggested PPE
1.	
2.	
3.	

Eye ANSI Z87.1 1989

Any potential of struck by, falling objects, flying objects or projectiles, chemical spills, splashes, noise, molten metals, acids or caustic liquids, chemical gases or vapors, dusts, harmful lights?

Hazards	Suggested PPE
1.	
2.	
3.	

Respiratory

Any potential for inhalation of hazardous materials (dusts, vapors, fumes, smoke, particulates, mists, etc.)? Check MSDS.

Hazards	Suggested PPE
1.	
2.	
3.	

FairPoint Communications, Inc.
Personal Protective Equipment Hazard Assessment

Skin or Clothing

Any potential for skin exposure to harmful substances or temperature extremes?

Hazards	Suggested PPE
1.	
2.	
3.	

Hands

Any exposure to chemical, sharp objects, temperature extremes, or other hazards?

Hazards	Suggested PPE
1.	
2.	
3.	

Foot Protection ANSI Z41.1991

Any potential for feet being exposed to crushing, struck by, rolled by materials being handled, or piercing of the sole of the shoe? Any special footwear requirement for the job?

Hazards	Suggested PPE
1.	
2.	
3.	

The hazard assessment has been completed and the following personal protective equipment is required. All affected employees must be trained in how to don, care for, maintain, use, and properly dispose of their personal protective equipment.

FairPoint Communications, Inc. Respiratory Medical Questionnaire

Company _____ Location _____

Employee _____

Birth Date ____ / ____ / ____ Age _____ Sex _____ Date _____

Height _____ Weight _____ Job Title _____

Phone Number _____ Best Time to Contact You _____

Has your employer told you how to contact the health care professional who will review this questionnaire: yes/no

Check the type of Respirator you will use: ___ N, P, or R disposable respirator (filter mask, non-cartridge)
 ___ Other type (half or full facepiece type, powered air, etc)

1.	Have you ever had any of the following conditions?	YES	NO
	Seizures (fits)		
	Diabetes (sugar disease)		
	Allergic reaction that interfere with your breathing		
	Claustrophobia (fear of closed places)		
	Trouble smelling odors		
2.	Have you ever had any of the following pulmonary or lung problems?		
	Asbestosis		
	Asthma		
	Chronic Bronchitis		
	Emphysema		
	Pneumonia		
	Tuberculosis		
	Silicosis		
	Pneumothorax		
	Lung Cancer		
	Broken Ribs		
	Any chest injuries or surgeries		
	Any other lung problem you've been told about		

FairPoint Communications, Inc. Respiratory Medical Questionnaire

3.	Do you currently have any of the following symptoms of pulmonary or lung illness?	Yes	No
	Shortness of breath when walking fast on level ground or up a hill		
	Shortness of breath when walking with other people at an ordinary pace on level ground		
	Have to stop for breath when walking at your own pace on level ground		
	Shortness of breath when washing or dressing yourself		
	Shortness of breath that interferes with your job		
	Coughing that produces phlegm		
	Coughing that wakes you early in the morning		
	Coughing that occurs mostly when you are lying down		
	Coughing up blood in the last month		
	Wheezing		
	Wheezing that interferes with your job		
	Chest pain when you breathe deeply		
	Any other symptoms that you think may be related to lung problems		
4.	Have you ever had any of the following cardiovascular or heart problems?		
	Heart Attack		
	Stroke		
	Angina		
	Heart failure		
	Swelling in your legs or feet not caused by walking		
	Heart arrhythmia		
	High blood pressure		
	Any other heart problem you've been told about		
	Any other lung problem you've been told about		
5.	Have you ever had any of the following cardiovascular or heart symptoms?		
	Frequent pain or tightness in your chest		
	Pain or tightness in your chest during physical activity		
	Pain or tightness in your chest that interferes with your job		

FairPoint Communications, Inc. Respiratory Medical Questionnaire

	In the past two years, have you noticed your heart skipping a beat	YES	NO
	Heartburn or indigestion that is not related to eating		
	Any other symptoms that you think may be related to heart or circulation problems		
6.	Do you currently take medication for any of the following problems?		
	Heart trouble		
	Blood pressure		
	Seizures		
7.	If you've ever used a respirator, have you ever had any of the following problems?		
	Eye irritation		
	Skin allergies or rashes		
	Anxiety		
	General weakness or fatigue		
	Any other problem that interferes with your use of the respirator		
8.	Would you like to talk to the health care professional that will review this questionnaire about your answers to this questionnaire?		

SMOKING SECTION

(Please check correct answer)

1. Do you smoke cigarettes? YES _____ NO _____
- How much?
Less than 1 pack _____
More than 1 pack _____
2. Have you ever smoked? If yes, for how long:
- 5 years _____
10 years _____
15 years _____
Longer _____
3. How much did you smoke then?
- Less than 1 pack _____
More than 1 pack _____

Signature _____ Date _____

Physician Recommendations: _____



RED TAG POLE REPORT

Fill out this form in its entirety and keep on permanent file..

Pole #		Date Reported:	
Line #		Date Reported:	
Exchange			
Employee Submitting Report:			
ENG Employee:			
Location:			
Problem:			
Course of Action:			

Additional Remarks:

OSHA No. 300, 300a & 301 Form

Download PDF file from www.osha.gov

Instructions for filling out these forms are included with the form.

FairPoint Communications, Inc. Automatic Sprinkler Systems Annual Inspection and Tests

Company: _____
System _____

Location: _____
Date _____

INSPECTOR				
GENERAL CONDITION Inspect sprinklers, sprinkler piping, pipe hangers, and seismic braces to ensure they are in good condition.				
FREEZING Before freezing weather, inspect building to ensure exterior wall openings will not expose sprinkler piping to freezing temperatures.				
MAINTAIN VALVES Valves should be maintained, including exercising each valve and lubricating each valve system.				
CLEAN STRAINERS Shut the water supply valve and remove the strainer for thorough cleaning.				
TEST ANTIFREEZE Wet pipe systems with antifreeze solution should have the solution checked for proper freeze level. Record freezing point.				
DRY PIPE SYSTEM Trip test the dry pipe valve. Record the time from opening the inspector test valve until the dry pipe valve trips.				
Internally inspect dry pipe valve.				
Test air pressure maintenance device.				
PREACTION SPRINKLER SYSTEM Trip test the preaction system. (Refer to manufacturer's instructions.)				
Internally inspect preaction valve.				
DELUGE SPRINKLER SYSTEM Trip test the deluge system. (Refer to manufacturer's instructions.)				
Internally inspect preaction valve.				
Check to see the water discharge pattern is adequate.				
Record water pressure at hydraulically most remote sprinkler.				
Record water pressure at deluge valve.				
Internally inspect deluge valve.				
COOKING EQUIPMENT SPRINKLERS Replace sprinklers with fusible links.				
COMMENTS:				

**FairPoint Communications, Inc.
Quarterly Facility Safety Review**

Month of _____, 20 ____

Company: _____ Location: _____

- _____ Visual check/marketing of all fire extinguishers
Needing service: _____ Not in place: _____

- _____ Check of overhead lighting/all working Needing service/replacement: _____
- _____ Housekeeping/General
- _____ _____ scraps cleaned up _____ aisles/exits clear
- _____ _____ rags/other disposed of properly _____ hand tools/equipment stored properly
- _____ _____ spills cleaned up properly _____ stored material safely/properly stacked/stored
- _____ Electrical cords in good repair
Needing service: _____ and pulled from use
- _____ Exit signs in place/in good repair
Needing replacement/missing: _____
- _____ Other safety signs in place/in good repair
Needing replacement/missing: _____
- _____ Check of hyster(s)/basic functions working
Needing repair (describe): _____
- _____ Guards in place on all equipment
Needing replacement: _____
- _____ Fire alarm working
Needing service: _____
- _____ Flammables properly stored
- _____ Container Storage: Labeled Closed Stored correctly
- _____ Personal Protective Equipment/on-hand/accessible
Stored properly, clean: _____
Need to order: _____
- _____ Ventilation system in working order: _____ Clean? _____ Needing service: _____
- _____ Other: _____

Inspection performed by: _____ Date: _____
Reviewed by (management representative): _____
Date of review: _____
Plan of action to address needs: _____

FairPoint Communications, Inc. Monthly Safety Inspection

Company: _____ Location: _____

Department _____

All Departments		Yes	No	Action Taken
1.	Are all first aid kits in good supply and readily available?			
2.	Are all machines properly guarded and guards in place?			
3.	Are all pinch points guarded on machinery and equipment?			
4.	Are all machines and tools electrically grounded?			
5.	Are all disconnect switches easily accessible?			
6.	Are push sticks provided for saws, joiners, and shapers?			
7.	Are all fan blades and belts caged?			
8.	Is shop kept neat daily and waste not allowed to accumulate around machines?			
9.	Are all decks and mezzanines properly guarded?			
10.	Are all ladders and stairways in good repair?			
11.	Are portable ramps and dock boards in safe condition?			
12.	Are electrical panels, switches, lighting fixtures, and electrical connections in good repair?			
13.	Is gasoline stored outside of building or in safety cans?			
14.	Is warehouse kept neat daily and metal straps kept off floor?			
15.	Is the OSHA poster on the bulletin board?			
16.	Do forklifts have horns and good brakes?			
17.	Are safety glasses worn where required?			
18.	Do hand drills and saws have good wiring?			

Safety Recommendations: _____

Inspected by: _____ Title: _____ Date: _____

Location Manager: _____ Date: _____

FairPoint Communications, Inc. Self-Inspection Report

Company: _____ Location: _____

Date: _____ Inspected by: _____

	YES	NO		YES	NO
HOUSEKEEPING			HAZARDOUS MATERIALS		
Are all aisles clearly marked?	<input type="checkbox"/>	<input type="checkbox"/>	Are all gas cylinders:		
Are all aisles clear?	<input type="checkbox"/>	<input type="checkbox"/>	1. Labeled?	<input type="checkbox"/>	<input type="checkbox"/>
Are all floors clear of tripping hazards (hoses, wires, pipes, etc.) ?	<input type="checkbox"/>	<input type="checkbox"/>	2. Secured?	<input type="checkbox"/>	<input type="checkbox"/>
Are all floors free of slipping hazards (oil, grease, sand, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	3. Capped?	<input type="checkbox"/>	<input type="checkbox"/>
Is all stock neatly arranged?	<input type="checkbox"/>	<input type="checkbox"/>	Are all flammables in safety cans?	<input type="checkbox"/>	<input type="checkbox"/>
Are all floors in good condition?	<input type="checkbox"/>	<input type="checkbox"/>	Are all cans/containers:		
Are suitable containers provided for waste materials and trash?	<input type="checkbox"/>	<input type="checkbox"/>	1. Labeled?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any combustible trash accumulations outside of proper containers?	<input type="checkbox"/>	<input type="checkbox"/>	2. In good condition?	<input type="checkbox"/>	<input type="checkbox"/>
Are flammable liquids safely handled and stored?	<input type="checkbox"/>	<input type="checkbox"/>	Are acids and flammables separated?	<input type="checkbox"/>	<input type="checkbox"/>
Are combustible packing materials kept in safe containers and is the packing area cleaned up at closing time?	<input type="checkbox"/>	<input type="checkbox"/>	Are bulk flammables stored in separate room/cabinet?	<input type="checkbox"/>	<input type="checkbox"/>
Is storage in warehouses orderly with ample aisle space?	<input type="checkbox"/>	<input type="checkbox"/>	Is room/cabinet in good condition?	<input type="checkbox"/>	<input type="checkbox"/>
			Are all metal drums grounded in flammable storage room?	<input type="checkbox"/>	<input type="checkbox"/>
MACHINE GUARDING			HAZARDOUS WASTE CONTAINER STORAGE		
Are all points of operation adequately guarded?	<input type="checkbox"/>	<input type="checkbox"/>	Are hazardous wastes being accumulated?	<input type="checkbox"/>	<input type="checkbox"/>
Are all drive mechanisms adequately guarded?	<input type="checkbox"/>	<input type="checkbox"/>	Are labels clearly marked, dated?	<input type="checkbox"/>	<input type="checkbox"/>
Are all interlocks operational?	<input type="checkbox"/>	<input type="checkbox"/>	Are drums in good condition (covered, clear of obstruction, no leaks)?	<input type="checkbox"/>	<input type="checkbox"/>
			Does spill station contain all listed materials?	<input type="checkbox"/>	<input type="checkbox"/>
			Volume of waste (# drums, or level in inches)?	<input type="checkbox"/>	<input type="checkbox"/>
			Have hazardous spill cleanup procedures been established?	<input type="checkbox"/>	<input type="checkbox"/>
			Is the proper absorbent material for spills available?	<input type="checkbox"/>	<input type="checkbox"/>
			Is all waste tightly sealed?	<input type="checkbox"/>	<input type="checkbox"/>
PERSONAL PROTECTIVE EQUIPMENT (Gloves, Glasses, Hearing Protection)			UNSAFE PRACTICES		
Is protective equipment available?	<input type="checkbox"/>	<input type="checkbox"/>	Are forklifts in good operating order?	<input type="checkbox"/>	<input type="checkbox"/>
Is protective equipment in good condition?	<input type="checkbox"/>	<input type="checkbox"/>	Are forklifts driven safely?	<input type="checkbox"/>	<input type="checkbox"/>
Is protective equipment usage enforced?	<input type="checkbox"/>	<input type="checkbox"/>	Is lifting done correctly?	<input type="checkbox"/>	<input type="checkbox"/>
Are all required employees wearing their equipment?	<input type="checkbox"/>	<input type="checkbox"/>	ELECTRICAL EQUIPMENT		
			Is electrical equipment grounded?	<input type="checkbox"/>	<input type="checkbox"/>
			Are all wires securely fastened?	<input type="checkbox"/>	<input type="checkbox"/>
			Is all wire in good condition?	<input type="checkbox"/>	<input type="checkbox"/>
			Are all electrical boxes covered?	<input type="checkbox"/>	<input type="checkbox"/>
			Is there any temporary wiring?	<input type="checkbox"/>	<input type="checkbox"/>
SMOKING					
Are there designated areas for smoking?	<input type="checkbox"/>	<input type="checkbox"/>			
Are "No Smoking" regulations enforced in restricted areas?	<input type="checkbox"/>	<input type="checkbox"/>			

FairPoint Communications, Inc.
Employee Authorization Form for Release of Information

Company: _____ Location: _____

In connection with my application for employment (including contract for services) with you, I understand consumer reports that may contain public record information may be requested from consumer reporting agencies. These reports may include the following types of information: *names and dates of previous employers, reason for termination of employment, work experience, accidents, etc.* I further understand that such reports may contain public record information concerning my driving record from federal, state, and other agencies that maintain such records, as well as information concerning previous driving record requests made by others such as state agencies, and state-provided driving records.

I authorize, without reservation any party or agency contacted to furnish the above-mentioned information.

I have the right to make a request, upon proper identification, to request the nature and substance of all information on me at the time of my request, including the sources of information and the recipients of any reports on me. I hereby consent to your obtaining the above information and I agree that such information, and my employment history with you, if I am hired, may be supplied to insurance companies and/or insurance agents and brokers for insurance underwriting purposes.

I hereby authorize procurement of consumer report(s). If hired (or contracted), this authorization shall remain on file and shall serve as ongoing authorization for you to procure consumer reports at any time during my employment (or contract) period.

Print Name

Social Security Number

Applicant Signature

Date

**FairPoint Communications, Inc.
New Driver Eligibility Form**

Name _____
Date _____

Company _____
Location _____
Department _____

Instructions:

1. This is a primary step, but not the only step, in the initial evaluation of a prospective driver employee.
2. Use the point evaluations on all driver applicants.
3. If the prospective driver has a driver evaluation score of 5 or higher, serious consideration should be given to his/her qualifications prior to driving and consultation with Risk Management is required.
4. Point assignment:

Age:	Points:
Under 25	2
25-55	0
Over 55	1

Work History: (Major Job Changes within last 5 Years)

None	0
1	1
2	2
More than 2	4

Any employment period of less than one year during the last five years is assessed an additional 1 point.

Major Moving Violations: (Within last 3 Years)

Points Per Infraction:

Hit and Run/Leaving the scene of an accident	6
Driving under the influence of alcohol or drugs	6
Any felony, homicide or manslaughter involving use of motor vehicle	6
Racing or excessive speeds (+10 mph over limit)	5
Reckless, negligent or careless driving	5
License suspension or revocation	5
Speeding (10 mph or less over speed limit)	3
At Fault Accidents	3

Other Moving Violations (Within last 3 years)

1

Grading:

Best	0-2
Average	3-4
Questionable	5-6
Poor	Over 6



Driver Evaluation Form

Employee	
Title	
Location	
Supervisor	
Date	

Reason for Evaluation

Driver Management Review Board Members (if applicable)

Manager/Supervisor	
Functional Lead	
Human Resources	
Risk Management	
Legal	
Other	

Offenses / Violations	Points	Date	Score
Conviction of an alcohol or substance abuse related driving offense	10		
Conviction of Negligent Homicide	10		
Using a motor vehicle for the commission of a Felony	10		
Conviction of Manslaughter/Aggravated Assault	10		
Conviction of Hit and Run	10		
Conviction of Grand Theft Auto			
Refusal to submit to a Blood Alcohol Content (BAC) test	7		
Conviction of Reckless Driving	7		
Non-disclosure, failure to report accidents or violations within the Company's allotted time frame, failure to follow Company Fleet Management Policies, failure to follow mandated guidelines	5		
Excessive Speed / +25 m.p.h.	5		
Preventable Accident – Total damages \$10,000 or greater	5		
Preventable Accident – Total damages less than \$10,000	3		
Conviction of a moving violation	1		
Incident / Non-preventable accident	1		
TOTAL SCORE:			

Comments

Recommendation

Approvals

Supervisor/Manager

Name

Signature

Date

Human Resources

Name

Signature

Date

If a Driver Management Review Board has been designated, each member must approve final recommendation.

**FairPoint Communications, Inc.
Vehicle Inspection Report**

PREVENTATIVE MAINTENANCE: PASSENGER CARS, VANS & PICK-UP TRUCKS

YEAR		MAKE	
MODEL		VIN	
MILEAGE		LOCATION	
DATE OF REPORT:		DRIVER:	

CHECK DEFECTS ONLY

- | | | |
|--------------------------------------------------------|-------------------------------------------------|-------------------------------|
| <input type="checkbox"/> Instruments/Gauges | <input type="checkbox"/> Horn | |
| <input type="checkbox"/> Windows/Windshield | <input type="checkbox"/> Rear/Side View Mirrors | |
| <input type="checkbox"/> Windshield Wipers/Washers | <input type="checkbox"/> Speedometer | |
| <input type="checkbox"/> Seat Belts | <input type="checkbox"/> Heater/Defroster | |
| <input type="checkbox"/> Head Lights | <input type="checkbox"/> Turn Signals | |
| <input type="checkbox"/> Brake Lights | <input type="checkbox"/> Tail Lights | |
| <input type="checkbox"/> Tires and Rims | <input type="checkbox"/> Steering | |
| <input type="checkbox"/> Brakes | <input type="checkbox"/> Radiator & Hoses | |
| <input type="checkbox"/> Water/Oil Leaks | <input type="checkbox"/> Transmission | |
| <input type="checkbox"/> Engine Performance | <input type="checkbox"/> Body Condition | Good <input type="checkbox"/> |
| <input type="checkbox"/> Accident Reporting Kit | | Fair <input type="checkbox"/> |
| <input type="checkbox"/> First Aid Kit | | Poor <input type="checkbox"/> |
| <input type="checkbox"/> Fire Extinguisher | | |
| <input type="checkbox"/> Insurance Card / Registration | | |

FairPoint Communications, Inc.
PREVENTATIVE MAINTENANCE: PASSENGER CARS, VANS & PICK-UP TRUCKS

Remarks

Maintenance Action

Repairs Completed: _____

Date Completed: _____

No Repairs Necessary _____

Driver Signature:

Date

Supervisor Name & Signature:

Name

Date

Signature

**FairPoint Communications, Inc.
Vehicle Inspection Report**

PREVENTATIVE MAINTENANCE: TRUCKS

Power Units

IN-CAB

- Gauges/Warning Indicators
- Windshield Wipers/Washers
- Horns
- Heater/Defroster
- Mirrors
- Steering
- Clutch
- Service Brakes
- Parking Brakes
- Emergency Brakes
- Triangles
- Fire Extinguisher
- Other Safety Equipment
- Spare Fuses
- Spare Belts
- Accident Reporting Kit
- First Aid Kit
- Insurance Card / Registration
- Other (identify)

EXTERIOR

- Lights
- Reflectors
- Suspension
- Tires/Tread Depth
- Wheels/Rims/Lugs
- Battery
- Exhaust
- Brakes
- Air Lines
- Light Line
- Fifth Wheel
- Other Coupling
- Tie-Downs
- Rear End Protection
- # of 36" Cones
- # of Other Cones
- Other (identify)

FairPoint Communicatins, Inc.
PREVENTATIVE MAINTENANCE: TRUCK CONDITION REPORT

Towed Unit (s)

Description: _____

___ Body/Doors	___ Suspension	___ Landing Gear	___ Rear-End Protection
___ Tie-Downs	___ Tires	___ Kingpin/Upper Plate	___
___ Other (identify)	___ Lights	___ Wheels	___ Rims
___ Lugs	___ Reflectors	___ Brakes	___ Fifth Wheel
___ Other Coupling Devices			

Remarks

Maintenance Action

Repairs Completed: _____ **Date Completed:** _____

No Repairs Necessary _____

Driver Signature:

Date

Supervisor Name & Signature:

Name

Date

Signature