

Appendix A: Building Safety Checklist

Building Checklist

Date:

Building name:

Item	Yes	No	NA	Correction Needed/Responsible Party	Date of Correction
Safety items					
Are there trip hazards?					
Are items stored properly in containers or on shelves?					
Are hazardous substances properly stored?					
Is the MSDS Book prominently located?					
Are fire escape routes posted in classrooms?					
Are fire escape routes clear and accessible?					
Is the Crisis Management Guide posted in classrooms?					
Are fire extinguishers charged and inspected?					
Are sharp objects properly stored?					
Maintenance items					
Are ceiling tiles wet or damaged?					
Are lights in good working condition?					
Is furniture and/or equipment in good repair?					
Are floor tiles in good repair?					
Is carpet in good repair?					
Misc.					

Bathroom Checklist

Date:

Building name:

Item	Yes	No	NA	Correction Needed/Responsible Party	Date of Correction
Is area clean, no mildew, and odor free?					
Are urinals/toilets working, clean, not broken?					
Are soap, towels, toilet paper & seat covers available?					
Are all water faucets working?					
Are all lights working?					
Are vents clean?					
Are the toilet tissue dispensers in good repair?					

Grounds Checklist

Date:

Building name:

Item	Yes	No	NA	Correction Needed/Responsible Party	Date of Correction
Are sidewalks unbroken?					
Are the outdoors areas neat and free of trash on the ground?					
Umbrellas/picnic tables & benches are in good repair?					
Ashtrays are in good repair?					
Lights are good working condition?					

Electrical/Mechanical Checklist

Date:

Building name:

Item	Yes	No	NA	Correction Needed/Responsible Party	Date of Correction
Floor clean and free of clutter?					
Are lights in good working condition?					
Are the log reports up to date?					
Are chemicals stored in this room?					
Are sinks clean and free of clutter?					

Physical Plant Checklist

Date:

Building name:

Item	Yes	No	NA	Correction Needed/Responsible Party	Date of Correction
Are tools in good safe working order?					
Are gloves available?					
Is hearing protection available?					
Is eye & face protection available?					
Are dust masks available?					
Are hazardous substances properly stored?					
Is the MSDS Book prominently located?					
Are fire extinguishers charged and inspected?					
Are materials stored clear of sprinklers head?					
Are all ladders in good condition?					
Is the storeroom orderly?					
Are exits and aisles of storeroom clear at all times?					

Are heavy items stored on the lower shelves?					
Are spillage items stored below eye level?					
Are objects that might roll blocked?					
Are exit doors clear of objects?					
Is food stored separate from other storage items?					

Appendix B: Incident Reporting Form (Maxient)




Incident Reporting Form

IF THERE IS AN IMMEDIATE RISK OF DANGER TO LIFE OR PROPERTY IMMEDIATELY CALL 911 OR THE DEPARTMENT OF PUBLIC SAFETY AND CAMPUS POLICE AT 434.981.6362.

PVCC cares about the safety and security of our community. Please use this form to report an incident or concerning behavior. You will be contacted once your report has been received. Note: If you send an anonymous report our ability to deal effectively with the concerning behavior may be limited.

Background Information

Your full name:	<input type="text"/>
Your position/title:	<input type="text"/>
Your phone number:	<input type="text"/>
Your email address:	<input type="text"/>
Your physical address:	<input type="text"/>
Nature of this report <small>(Required)</small> :	<input type="text" value="Please Choose..."/>
Urgency of this report:	<input type="text" value="Non-Urgent"/>
Date of Incident <small>(Required)</small> :	<input type="text" value="YYYY-MM-DD"/> 
Time of Incident:	<input type="text"/>
Location of Incident <small>(Required)</small> :	<input type="text" value="Please select a location ..."/>
Specific location:	<input type="text"/>

Involved Parties

Please list the individuals involved (excluding yourself), including as many of the listed fields as you can provide. For non-students, please list an SSN or Drivers License number in the block labeled SID (Student ID #) if available.

Name or Organization	Select Gender	Select Role	ID Number
<input type="text"/>	Please choose... ▾	Please choose... ▾	<input type="text"/>
DOB (YYYY-MM-DD)	Phone number	Email address	Hall/Address
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Add another

Questions

Please indicate the relevant category(s) that pertain to this incident report.

ACADEMIC INTEGRITY

- Buying, selling, stealing or soliciting examination content
- Cheating
- Plagiarism
- Substitution for another person during an exam
- Unauthorized collaboration on assignments

CLASSROOM CONDUCT

- Disruption or obstruction of teaching/learning environment
- Profanity
- Unauthorized use of cellular phones and other electronic devices
- Unauthorized visitors
- Unruly, disruptive, or hostile behavior toward instructor/other students

CONCERNING AND THREATENING BEHAVIOR

- Aggressive behavior
- Alarming references to bombs, ammunition, firearms
- Depression/sadness/crying
- Disrespectful behavior
- Disruptive/disturbing behavior
- Disturbing classroom discussion
- Disturbing written materials
- Erratic behavior
- Excessive anxiety
- Extreme rudeness
- Flat affect or extreme lack of responsiveness
- Harassment
- Hostile behavior
- Incoherent speech
- Insubordination to college official
- Self destructive behavior (cutting, burning, etc.)
- Suicidal expressions
- Threat of violent behavior
- Verbal threats (including electronic communication and social media)
- Violent/threatening behavior

GENERAL MISCONDUCT

- Altering college documents to defraud
- Attending a course without proper registration
- Being under the influence of alcohol and/or illegal drugs
- Computer misuse
- Disruptive behavior outside the classroom
- Encouraging others to commit prohibited acts
- Failure to comply with a request of a college official
- Forgery/alteration/misuse of College documents
- Providing false information
- Selling back another person's textbooks or property to the bookstore
- Unauthorized student organization
- Verbal/non-verbal harrasment (including profanity)
- Violation of College policy on demonstratio

INCIDENTS INVOLVING SEXUAL VIOLENCE/HARASSMENT

- Sexual assault
- Sexual harassment
- Sexual misconduct
- Sexual violence
- Stalking

INJURY/ILLNESS

- Employee Injury - contact HR within 24 hours of report
- High Risk Program Accident
- Illness
- Injury

SECURITY INCIDENT

- Alcohol - Possession, consumption, sale or serving of alcoholic beverages
- Automobile accident/incident
- Brandishing firearms
- Child unattended
- Disorderly conduct
- Drug - Sale, distribution, use, or possession
- Fire
- Gambling
- Littering, defacing, destroying or damaging property
- Non-compliance with College computer policies
- Obstructing/restraining movement of a
- Refusing to depart from property
- Theft or attempted theft
- Trespassing
- Unauthorized entry
- Unauthorized use of College property
- Unauthorized use of sound equipment
- Violating local, state or federal laws

illegal/controlled substances

- Failure to comply
- Failure to furnish identification
- Fighting/physical altercation

person or vehicle

- Participating in or inciting a riot/disorderly assembly
- Physical abuse
- Possession of a deadly weapon
- Providing false material statements

- Violation of College policy on solicitation and sales

Please provide a detailed description of the incident/concern using **specific** concise, objective language (Who, what, where, when, why, and how). For "Illness or injury" reports, please list the part of your body where you were injured.

Supporting Documentation

Photos, video, email, and other supporting documents may be attached below. 1GB maximum total size.

Attachments require time to upload, so please be patient after submitting this form.

Choose files to upload

Choose Files


Select copy recipients

- | | |
|---|--|
| <input type="checkbox"/> Teresa Willis, Human Resources Manager & Title IX Coordinator | <input type="checkbox"/> Adam Hastings, Dean of Business, Mathematics, and Technologies |
| <input type="checkbox"/> John Donnelly, Vice President for Instruction and Student Services | <input type="checkbox"/> Susan Hannifan, Disabilities Services Counselor |
| <input type="checkbox"/> Cliff Haury, Dean of Humanities, Fine Arts, and Social Sciences | <input type="checkbox"/> Jean Chappell, Dean of Health and Life Sciences and Human Services |
| <input type="checkbox"/> Kim McManus, Vice President of Finance | <input type="checkbox"/> Rebecca Parkhill, Administrative Assistant to Vice President of Finance |
| <input type="checkbox"/> Mary Lee Walsh, Dean of Student Services | <input type="checkbox"/> Pat Buck, Assistant to the President |
| <input type="checkbox"/> Valerie Palamountain, Dean of Workforce Services | <input type="checkbox"/> Crystal Newell, Director of Library Services |
| <input type="checkbox"/> Sue Haas, Chief Information Officer | |

One last step ...

Help us prevent spam reports by completing this captcha.

NOTE: If you do not see a gray box with a checkbox that says "I'm not a robot", please try a different web browser.

I'm not a robot
 

- Email me a copy of this report

Submit report

Appendix C: Hepatitis B Vaccine Declination Statement

MANDATORY HEPATITIS B VACCINATION DECLINATION FORM

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

NAME _____

POSITION _____

DATE _____

WITNESS _____

DATE _____

*Appendix D: DOT Hazard Classification List,
EPA Hazard Classification List*

DOT HAZARD CLASSIFICATION LIST

HAZARD	Classification	EXAMPLE
1. Radioactive material		CO-60 or I-130
2. Flammable		liquids Alcohol
3. Non-flammable compressed	gases	Nitrogen
4. Flammable		gases Oxygen
5. Oxidizer		Nitric acid
6. Corrosive	material	Hydrochloric acid
7. Irritating	material	Lacramator
8. Poison	A	Heptachlor
9. Poison	B	Phenol
10. Organic	peroxide	Benzoyl peroxide
11. ORM-A*		Formaldehyde
12. ORM-B*		Mercury
13. ORM-D*		Bleach
14. ORM-E*		Ferric sulfate
15. Etiological	agents	Microorganisms (E. coli)

*ORM = Other Regulated Material

Appendix E: Lockout/Tagout Procedures for Specific Equipment

**LOCKOUT-TAGOUT PROCEDURE
PIEDMONT VIRGINIA COMMUNITY COLLEGE**

Created: _____ Machine/Equipment: _____
Revised: _____ Location (s): _____
Lockout Control Number: _____ Number of Lockout Points: _____
Sources of Hazards: _____
Authorized Employees: _____
Affected Employees: _____
Notes: _____

Lockout Application Process (process for each lockout point):

Location of lockout point: _____	Required lockout equipment: _____
1. _____	
2. _____	
3. _____	
4. _____	

Lockout Removal Process:

1. _____
2. _____
3. _____
4. _____
5. _____

Completed By: _____

Appendix F: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee:

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date: _____

2. Your name: _____

3. Your age (to nearest year): _____

4. Sex (circle one): Male/Female

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

7. Your job title: _____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____

9. The best time to phone you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

11. Check the type of respirator you will use (you can check more than one category):

a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

b. _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-

contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s): _____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month: Yes/No

2. Have you *ever had* any of the following conditions?

a. Seizures: Yes/No

b. Diabetes (sugar disease): Yes/No

c. Allergic reactions that interfere with your breathing: Yes/No

d. Claustrophobia (fear of closed-in places): Yes/No

e. Trouble smelling odors: Yes/No

3. Have you *ever had* any of the following pulmonary or lung problems?

a. Asbestosis: Yes/No

b. Asthma: Yes/No

c. Chronic bronchitis: Yes/No

d. Emphysema: Yes/No

e. Pneumonia: Yes/No

f. Tuberculosis: Yes/No

g. Silicosis: Yes/No

h. Pneumothorax (collapsed lung): Yes/No

i. Lung cancer: Yes/No

j. Broken ribs: Yes/No

- k. Any chest injuries or surgeries: Yes/No
- l. Any other lung problem that you've been told about: Yes/No
- 4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?
 - a. Shortness of breath: Yes/No
 - b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No
 - c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No
 - d. Have to stop for breath when walking at your own pace on level ground: Yes/No
 - e. Shortness of breath when washing or dressing yourself: Yes/No
 - f. Shortness of breath that interferes with your job: Yes/No
 - g. Coughing that produces phlegm (thick sputum): Yes/No
 - h. Coughing that wakes you early in the morning: Yes/No
 - i. Coughing that occurs mostly when you are lying down: Yes/No
 - j. Coughing up blood in the last month: Yes/No
 - k. Wheezing: Yes/No
 - l. Wheezing that interferes with your job: Yes/No
 - m. Chest pain when you breathe deeply: Yes/No
 - n. Any other symptoms that you think may be related to lung problems: Yes/No
- 5. Have you *ever had* any of the following cardiovascular or heart problems?
 - a. Heart attack: Yes/No
 - b. Stroke: Yes/No
 - c. Angina: Yes/No
 - d. Heart failure: Yes/No

e. Swelling in your legs or feet (not caused by walking): Yes/No

f. Heart arrhythmia (heart beating irregularly): Yes/No

g. High blood pressure: Yes/No

h. Any other heart problem that you've been told about: Yes/No

6. Have you *ever had* any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest: Yes/No

b. Pain or tightness in your chest during physical activity: Yes/No

c. Pain or tightness in your chest that interferes with your job: Yes/No

d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No

e. Heartburn or indigestion that is not related to eating: Yes/No

d. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

7. Do you *currently* take medication for any of the following problems?

a. Breathing or lung problems: Yes/No

b. Heart trouble: Yes/No

c. Blood pressure: Yes/No

d. Seizures: Yes/No

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)

a. Eye irritation: Yes/No

b. Skin allergies or rashes: Yes/No

c. Anxiety: Yes/No

d. General weakness or fatigue: Yes/No

e. Any other problem that interferes with your use of a respirator: Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you *ever lost* vision in either eye (temporarily or permanently): Yes/No

11. Do you *currently* have any of the following vision problems?

a. Wear contact lenses: Yes/No

b. Wear glasses: Yes/No

c. Color blind: Yes/No

d. Any other eye or vision problem: Yes/No

12. Have you *ever had* an injury to your ears, including a broken ear drum: Yes/No

13. Do you *currently* have any of the following hearing problems?

a. Difficulty hearing: Yes/No

b. Wear a hearing aid: Yes/No

c. Any other hearing or ear problem: Yes/No

14. Have you *ever had* a back injury: Yes/No

15. Do you *currently* have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet: Yes/No

b. Back pain: Yes/No

c. Difficulty fully moving your arms and legs: Yes/No

d. Pain or stiffness when you lean forward or backward at the waist: Yes/No

e. Difficulty fully moving your head up or down: Yes/No

f. Difficulty fully moving your head side to side: Yes/No

g. Difficulty bending at your knees: Yes/No

h. Difficulty squatting to the ground: Yes/No

i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No

j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes/No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes/No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No

If "yes," name the chemicals if you know them: _____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos: Yes/No

b. Silica (e.g., in sandblasting): Yes/No

c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No

d. Beryllium: Yes/No

e. Aluminum: Yes/No

f. Coal (for example, mining): Yes/No

g. Iron: Yes/No

h. Tin: Yes/No

i. Dusty environments: Yes/No

j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures: _____

4. List any second jobs or side businesses you have: _____

5. List your previous occupations: _____

6. List your current and previous hobbies: _____

7. Have you been in the military services? Yes/No

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you ever worked on a HAZMAT team? Yes/No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes/No

If "yes," name the medications if you know them: _____

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters: Yes/No

b. Canisters (for example, gas masks): Yes/No

c. Cartridges: Yes/No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

a. Escape only (no rescue): Yes/No

b. Emergency rescue only: Yes/No

c. Less than 5 hours *per week*: Yes/No

d. Less than 2 hours *per day*: Yes/No

e. 2 to 4 hours per day: Yes/No

f. Over 4 hours per day: Yes/No

12. During the period you are using the respirator(s), is your work effort:

a. *Light* (less than 200 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.

b. *Moderate* (200 to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or *pushing* a wheelbarrow with a heavy load (about 100 lbs.) on a level surface. c. *Heavy* (above 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; *shoveling*; *standing* while bricklaying or chipping castings; *walking* up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No

If "yes," describe this protective clothing and/or equipment: _____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No

15. Will you be working under humid conditions: Yes/No

16. Describe the work you'll be doing while you're using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

The name of any other toxic substances that you'll be exposed to while using your respirator:

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998; 76 FR 33607, June 8, 2011; 77 FR 46949, Aug. 7, 2012]

*Appendix G: Specific Safety Procedures For
High Risk Instructional Programs*

HIGH RISK INSTRUCTIONAL PROGRAMS

SPECIFIC SAFETY PROCEDURES FOR

(NAME OF PROGRAM)

Reference PVCC Safety Manual Section 13 for appropriate policies related to each of these areas.

SUPERVISION OF STUDENTS IN LABS (SECTION 13.1)

LAB/CLASSROOM SAFETY (SECTION 13.3)

PERSONAL PROJECTS IN LABS (SECTION 13.4)

CLASSROOM & LAB RULES OF BEHAVIOR / CODE OF CONDUCT (SECTION 13.6)

SAFETY TESTING (SECTION 13.8)

EMERGENCY TRAINING (SECTION 13.10)

COURSE SYLLABUS (SECTION 13.11 AND 13.12)

EQUIPMENT INSPECTIONS (SECTION 13.14)

Appendix H: Bloodborne Pathogens Exposure Incident Procedures

These procedures shall be posted in all areas at Piedmont Virginia Community College where there is the possibility of an exposure to blood borne pathogens resulting from the performance of an employee's duties.

**** BLOOD BORNE PATHOGENS EXPOSURE INCIDENT PROCEDURES ****

In the event of an exposure incident (a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials), the following procedures shall be followed.

- (1) The exposed employee shall **IMMEDIATELY** wash the affected skin with soap and water or germicidal towelette and/or flush mucous membrane with water.
- (2) The scene of the incident, including any equipment, floors and sinks, shall be immediately and thoroughly cleaned and disinfected with an appropriate disinfectant.
- (3) The employee shall inform his/her supervisor of the incident as soon as possible.
- (4) The supervisor shall advise the human resources officer and the vice president for finance and administrative services.
- (5) The Human Resources Officer shall:
 - (a) Arrange for the employee to receive a Hepatitis B vaccination if the employee has not received one previously. If the employee declines the vaccination, he/she shall be required to sign a declination statement.
 - (b) Upon consent of the employee, arrange to have the employee's blood collected for testing at the designated healthcare facility.
 - (c) Arrange to have the blood of the source individual tested, if a specimen is available or upon consent of the source individual, if the infectious status is unknown.
 - (d) Assure that the employee is informed of the results of the source individual's blood test.

- (e) Arrange for the employee to have post-exposure prophylaxis, counseling and medical evaluation if necessary.
 - (f) Provide the employee with a copy of the healthcare professional's written opinion within 15 days of the evaluation.
- (6) The supervisor will investigate the exposure incident within 24 hours and will report the results to the vice president for finance and administrative services.