

Step 1 – Work Description (to be completed by the submitter)

Requestor: _____ Date: _____ Phone: _____ Organization: _____

Proposed Start Date: _____ Required Completion Date: _____ Location of Work: _____

Task: Repair/Testing Maintenance/1-for-1 New/Modified Installation Labyrinth/Mini-Hutch **Risk Level:** Low Medium High

Component Type: Shutter/ACIS Stop Radiation Shielding PSS/ACIS **RSS Other:** _____ **RSS Label:** _____

Machine: LINAC PAR Booster Zone F Storage Ring LEUTL Front Ends Experimental Floor

Step 2 – JOB TITLE: _____

Job Description: _____

WORK REQUEST #: _____

PROCEDURE/CHECKLIST #: _____

DIVISION APPROVAL TO PROCEED ICMS #: _____

Work Approvals:

	Approval Signature	Date	Approval Signature	Date
Safety Interlocks:	_____	_____	Mechanical/Water:	_____
Vacuum:	_____	_____	Survey/Alignment:	_____
RF/PS/Diag/CTL:	_____	_____	MED:	_____
Health Physics:	_____	_____	ADD:	_____
MCR/OA:	_____	_____	CCSM:	_____

Step 3 – Authorization to Start. Information (drawings, specs, procedures, approval/validation checklist requirements, review committee recommendations etc.) are adequate to safely complete work, requested work is consistent with an approved design, and a pre-work briefing has been held.

(RSSE, Responsible Engineer) : _____ Date : _____

Stations Enabled: _____ Stations Disabled: _____ Global: On-line Off-line

MCR/Floor Coordinator: _____ Date : _____

Step 4 – Validations: Responsible Engineer indicates work has been completed, validated, all safety concerns have been resolved, and all appropriate records have been updated.

	Validator's Signature	Date	Validator's Signature	Date
Safety Interlocks:	_____	_____	Mechanical/Water:	_____
Vacuum:	_____	_____	Survey/Alignment:	_____
RF/PS/Diag/CTL:	_____	_____	MED:	_____
Health Physics:	_____	_____	ADD:	_____
MCR/OA:	_____	_____	Other	_____

Step 5 – Close out complete: All work and validations completed.

CCSM : _____ Date: _____

Floor Coordinator / MCR : _____ Date: _____

RSSE / Responsible Engineer : _____ Date: _____

Step 6 – Return to service. Type C Radiation Survey Required: Yes No Survey Completed (HP) : _____ Date: _____

Device/system ready to return to service, on-line status restored: Floor Coordinator / MCR: _____ Date: _____

Comments:

RETURN THE COMPLETED CCWP TO THE APPROPRIATE PERSON TO BE SCANNED INTO ICMS