SHUTDOWN REQUEST FORM

Requested By: _____ Date: _____

Project Name: _____ Project Number: _____

Contractor/Subcontractor
Contact Person: _____ Work # _____ Emer. # _____

What Utility or Service will be affected? _____

_____

What Areas will be affected: _____

_____

What is the reason for this Shutdown? _____

Estimated length of time Utility or Service will be interrupted: _____

Preferred Time and Date: _____

Maintenance Supervisor Handling Shutdown _____

Assigned Time and Date: _____

Name of each person notified:

	OF PLANNED SHUTDOWN			OF RESTORED SERVICES	
NAME & AREA	**TIME**	**DATE**	**PHONE**	**TIME**	**DATE**

Status: _____

Comments: _____

_____

Out of Service Tag Removed: Yes _____ No _____

Approval: _____
Maintenance Engineer Date

_____
Maintenance Department Date

_____
Hospital Administration Date

NOTE: If service is not restored the same day, a report must be filed with the Director of Hospital Maintenance.