

single convictions. This study used 3 consecutive years of data, comparing the experiences of drivers in the first 2 years with their experiences in the final year.

Applying principles from these studies to the past 3-year record of the 14 applicants, none of the applicants was involved in crashes and one applicant was convicted of two moving violations in a CMV for speeding. All the applicants achieved a record of safety while driving with their vision impairment, demonstrating the likelihood that they have adapted their driving skills to accommodate their condition. As the applicants' ample driving histories with their vision deficiencies are good predictors of future performance, FMCSA concludes their ability to drive safely can be projected into the future.

We believe that the applicants' intrastate driving experience and history provide an adequate basis for predicting their ability to drive safely in interstate commerce. Intrastate driving, like interstate operations, involves substantial driving on highways on the interstate system and on other roads built to interstate standards. Moreover, driving in congested urban areas exposes the driver to more pedestrian and vehicular traffic than exists on interstate highways. Faster reaction to traffic and traffic signals is generally required because distances between them are more compact. These conditions tax visual capacity and driver response just as intensely as interstate driving conditions. The veteran drivers in this proceeding have operated CMVs safely under those conditions for at least 3 years, most for much longer. Their experience and driving records lead us to believe that each applicant is capable of operating in interstate commerce as safely as he/she has been performing in intrastate commerce. Consequently, FMCSA finds that exempting these applicants from the vision requirement in 49 CFR 391.41(b)(10) is likely to achieve a level of safety equal to that existing without the exemption. For this reason, the Agency is granting the exemptions for the 2-year period allowed by 49 U.S.C. 31136(e) and 31315 to the 14 applicants listed in the notice of October 17, 2011 (76 FR 64169).

We recognize that the vision of an applicant may change and affect his/her ability to operate a CMV as safely as in the past. As a condition of the exemption, therefore, FMCSA will impose requirements on the 14 individuals consistent with the grandfathering provisions applied to drivers who participated in the Agency's vision waiver program.

Those requirements are found at 49 CFR 391.64(b) and include the following: (1) That each individual be physically examined every year (a) by an ophthalmologist or optometrist who attests that the vision in the better eye continues to meet the requirement in 49 CFR 391.41(b)(10), and (b) by a medical examiner who attests that the individual is otherwise physically qualified under 49 CFR 391.41; (2) that each individual provide a copy of the ophthalmologist's or optometrist's report to the medical examiner at the time of the annual medical examination; and (3) that each individual provide a copy of the annual medical certification to the employer for retention in the driver's qualification file, or keep a copy in his/her driver's qualification file if he/she is self-employed. The driver must also have a copy of the certification when driving, for presentation to a duly authorized Federal, State, or local enforcement official.

Discussion of Comments

FMCSA received one comment in this proceeding. The comment was considered and discussed below.

Laura J. Krol of the Pennsylvania Department of Transportation is in favor of granting David A. Rice an exemption.

Conclusion

Based upon its evaluation of the 14 exemption applications, FMCSA exempts, Kevin G. Clem (SD), Richard A. Hackney (MS), Rocky J. Lachney (LA), Herman Martinez (NM), Charles L. McClendon (FL), Gerald L. Pagan (NC), Danny C. Pope (IL), David A. Rice (PA), Levi A. Shelter (OH), Rick E. Smith (IL), Juan E. Sotero (FL), Randall K. Tyler (AL), Steven R. Wetlesen (AL) and Jeffrey K. Yockey (OH) from the vision requirement in 49 CFR 391.41(b)(10), subject to the requirements cited above (49 CFR 391.64(b)).

In accordance with 49 U.S.C. 31136(e) and 31315, each exemption will be valid for 2 years unless revoked earlier by FMCSA. The exemption will be revoked if: (1) The person fails to comply with the terms and conditions of the exemption; (2) the exemption has resulted in a lower level of safety than was maintained before it was granted; or (3) continuation of the exemption would not be consistent with the goals and objectives of 49 U.S.C. 31136 and 31315.

If the exemption is still effective at the end of the 2-year period, the person may apply to FMCSA for a renewal under procedures in effect at that time.

Issued on: November 28, 2011.

Larry W. Minor,

Associate Administrator for Policy.

[FR Doc. 2011-31164 Filed 12-2-11; 8:45 am]

BILLING CODE 4910-EX-P

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

Safety Advisory 2011-03

AGENCY: Federal Railroad Administration (FRA), Department of Transportation (DOT).

ACTION: Notice of Safety Advisory; Bridge Walkway Hazards.

SUMMARY: FRA is issuing Safety Advisory 2011-03 to remind each railroad bridge worker, railroad, and contractor or subcontractor to a railroad of the dangers posed by walking on unsecured sections of walkway and platform gratings, especially without fall protection. This safety advisory contains various recommendations to the employers of bridge workers to ensure that this issue is addressed by appropriate policies, procedures, and employee compliance.

FOR FURTHER INFORMATION CONTACT: Ron Hynes, Director, Office of Safety Assurance and Compliance, Office of Railroad Safety, FRA, 1200 New Jersey Avenue SE., Washington, DC 20590, telephone (202) 493-6404; Carlo Patrick, Staff Director, Rail and Infrastructure Integrity Division, Office of Railroad Safety, FRA, 1200 New Jersey Avenue SE., Washington, DC 20590, telephone (202) 493-6399; or Alan H. Nagler, Senior Trial Attorney, Office of Chief Counsel, FRA, 1200 New Jersey Avenue SE., Washington, DC 20590, telephone (202) 493-6049.

SUPPLEMENTARY INFORMATION: In 1992, FRA established safety standards for the protection of those who work on railroad bridges at Title 49 Code of Federal Regulations (CFR) part 214, subpart B. The regulations require railroads and railroad contractors to provide, and employees to use, fall protection and personal protective equipment, including head, foot, eye, and face equipment for employees as they work on railroad bridges. The regulation also contains standards related to scaffolding. The purpose of FRA's bridge worker safety standards regulation is to prevent accidents and casualties to employees involved in certain railroad inspection, maintenance, and construction activities.

The purpose of this safety advisory is to focus attention on the unsafe

practices preliminarily found to be potential contributing causes in two incidents occurring this year that resulted in two workers falling from railroad bridges, one sustaining a fatal injury. In 2008, another worker fell under similar circumstances. In each of these three incidents, the fallen bridge worker was not using a personal fall arrest system and fell when stepping on an unsecured walkway or platform grating. The responsible railroads, contractors, and subcontractors had also not erected a safety net system. Furthermore, in each instance, the unsecured grating is known or presumed to have flipped or tipped as it was found to have fallen along with the worker. By focusing attention on these accidents, FRA intends to raise awareness and hopefully prevent a continuing pattern of accidents involving similar circumstances.

Results of Preliminary Investigations

The following discussion of the circumstances surrounding the three incidents noted above is based on FRA's preliminary investigations. FRA did not conduct full investigations of the August 25, 2008, and May 20, 2011, incidents, and does not plan to produce final findings or reports for either of these two incidents. In addition, the September 19, 2011, fatal incident described in this safety advisory is still under investigation by FRA. Because their causes and contributing factors, if any, have not been formally established, nothing in this safety advisory should be construed as placing blame or responsibility for any of these accidents on the acts or omissions of any person or entity.

Vermillion, Ohio: August 25, 2008

At 5:55 p.m., a Norfolk Southern Railway (NS) bridge worker fell from a Vermillion River railroad bridge, struck a concrete bridge pier, and then fell into the river. The worker fell nearly 35 feet. Fortunately, NS had hired a contractor to search for and retrieve sunken bridge ties and the contractor's employees saw the NS worker fall. The worker was reportedly in great pain and struggling to keep his head above water when a diver for the contractor, who was already in the water, rescued the worker. As a result of this accident, the worker suffered a dislocated right shoulder.

The bridge is a 3-span, deck plate girder bridge with an open deck, and upon which there are two tracks. As part of a bridge tie replacement project, workers were installing bridge tie spacing timbers on the newly installed bridge ties on Track 1. Track 1 was

occupied by on-track equipment. The worker had worked alongside an assistant foreman (*i.e.*, the roadway worker-in-charge of the working limits) for most of the work period in order to learn how to permit train movements past the stop boards on adjacent Track 2. As the stop boards were in effect until 5 p.m., the worker took the stop boards down soon thereafter and an alternative form of Roadway Worker Protection was established.

After the worker took the stop boards down, he began walking on sections of a walkway grating located on the bridge between the two tracks so that he could drill holes in the timber tie spacers. The grating on that walkway was mainly in 20-foot-long sections. The walkway sections were not secured to the bridge ties as the usual practice was to secure the metal walkway grating at the end of the work day.

One section of grating was only approximately 8 feet long. This shorter section of walkway was supported in the middle with a 14-foot long "outrigger" tie. The worker stepped on one end of the 8-foot section of walkway, which was overlapping a 19-foot section of walkway on the opposite end. There was no tie support underneath the end that the worker stepped on. As a result, the employee's body weight caused the 8-foot section of walkway to pivot downward on the 14-foot long "outrigger" tie. This action allowed the grating to drop between the tracks and the worker to fall into the river.

Minooka, Illinois: May 20, 2011

An accident occurred in Minooka, Illinois, at approximately 7:30 a.m. when a bridge worker stepped on a section of unsecured platform grating and fell approximately 11 feet to a cross-brace. The worker landed on his back, and, at the time of the accident, appeared to have bruises on his back and shoulders. A subcontractor, hired by the general contractor, employed the worker primarily to torque bolts on a railroad bridge owned by Canadian National Railway (CN). On May 25, 2011, the worker died. Although the coroner did not determine that the injuries sustained in the fall from the bridge were the primary cause of death, the coroner found that the blunt trauma due to the fall may have been a significant condition contributing to death but not related to the underlying cause of death.

On May 16, 2011, 5 days prior to the accident, the worker had raised safety concerns with the safety manager for the general contractor regarding that the grating on the platform was not properly

installed. The safety manager agreed with the worker that the grating was not installed properly and consulted the subcontractor responsible for installing grating for platforms on this job. A coworker of the involved worker noticed that there were up to 6-inch gaps between several of the pieces of grating and that nothing was fastening the individual pieces to the structure on this platform located 103 feet above the water at the top of a vertical lift bridge counterweight tower. The safety manager reported back to the involved worker that it would be difficult to properly install the grating with all of the heavy tools and machinery on the platform and that the weight of all the tools and machinery was holding the grating in place. The safety manager believed that workers did not need fall protection or restraints because the platform had a 42-inch-high hand railing surrounding the perimeter. The coworker of the involved worker noticed that between May 16 and May 19, the tool boxes and heavy equipment on the platform were gradually removed so the machinists could use the tools and equipment at other locations. Although the two workers had previously used fall protection on a different platform while working on this same bridge, the coworker did not consider using fall protection because of the presence of the hand rails on this platform.

The accident occurred approximately 15 minutes after a job briefing covering trip and fall hazards at the work site. The two workers climbed the stairs that led to the platform. Approximately 5 minutes after reaching the platform, the coworker heard a loud crash and turned around to see that the involved worker was no longer on the platform. The coworker noticed a piece of grating missing that was approximately 4 feet square. The coworker could see the worker lying on his back on an approximately 10-inch-wide horizontal I-beam that was located 11 feet below the platform. The coworker was able to help the involved worker get up a ladder to the platform before contacting the employee-in-charge for further assistance.

Havre de Grace, Maryland: September 19, 2011

A fatal accident occurred at approximately 1:50 p.m. when a CSX Transportation, Inc.'s (CSX) bridge worker fell approximately 75 feet from the Susquehanna River Bridge in Havre de Grace, Maryland. The deceased worker was a 58-year-old man with approximately 38 years of railroad service. The deceased worker was a

member of a six-person bridge worker team that was engaged in the replacement of bridge ties on the structure. The equipment at the work site included an on-track tie handler and a hi-rail boom truck.

Although there were no witnesses to the actual fall, FRA's preliminary investigation suggests that the deceased stepped on the unsupported end of an unsecured, 85-inch-long section (*i.e.*, 7 feet 1 inch) of steel walkway grating. The missing walkway grating location was measured at 75 inches long and was outside the rails. Aside from the 85-inch-long section of grating found on the ground near the deceased, all the grating observed in the area of the extended work site were found to be in sections that were 20 feet long. Additionally, each section of grating in the area of the extended work site was unsecured. At the accident site, the walkway railing was not in place.

The hi-rail boom truck was occupying the track next to the missing walkway grating. This truck was equipped with a horizontal life line for connecting a harness. The preliminary investigation suggests that the truck's horizontal life line may not have been long enough so that a worker could be provided with fall protection while walking along the entire side of the truck. A safety net system was not used. The deceased was wearing a harness. Preliminary findings also suggest that the deceased worker was not distracted by any personal electronic devices.

Safety Issues

Fall Protection

Generally, when bridge workers work 12 feet or more above the ground or water surface, FRA regulations require that a personal fall arrest system or safety net system be provided and used. 49 CFR 214.103. Fall protection is a system used to arrest the fall of a person from a working level. It consists of an anchorage, connectors, body harness, lanyard, deceleration device, lifeline, or a combination of these. 49 CFR 214.7 (defining "personal fall arrest system"). Although there are some exceptions to the requirement that fall protection be used, FRA's preliminary investigations indicate that none of the exceptions applied to any of the incidents described in this safety advisory.

As stated previously, FRA's bridge worker safety standards are premised on the broad requirements that railroads and railroad contractors provide fall protection for employees as they work on railroad bridges—and that the employees, when warranted, must use the fall protection provided. In the

investigation of each incident, it was preliminarily found that the railroad, contractor, or subcontractor had provided the personal fall arrest system but that the bridge worker did not use the personal fall arrest system at the time of the incident. Because the failure to use a personal fall arrest system appears to have played a role in each of these incidents, FRA believes it is necessary to stress the importance of bridge workers using the personal fall arrest system provided to them.

However, the agency in no way suggests that these incidents resulted only from each worker's failure to use a personal fall arrest system. The preliminary investigations suggest that there were a number of potential causes or contributing factors. For instance, supervisors were apprised of the unsecured grating but did not necessarily assess the dangers posed or take reasonable steps to mitigate the potential threat to worker safety. The preliminary investigations suggest that supervisors and employers could have taken additional steps to protect bridge workers by putting up safety net systems, securing the grating, ensuring that the fall protection provided would be adequate under actual working conditions, and emphasizing specific actions during the job safety briefings where the use of the provided personal fall arrest system would be required by law.

Grating

Typical steel bridge walkway grating is supplied in 20-foot lengths, with the standard widths of 24, 30, or 36 inches. The grating weighs about 9 pounds per square foot. Where long bridge ties are used as outriggers to support the grating, spacing of these outrigger ties normally range from 4 feet 8 inches to 5 feet 4 inches, center to center. Walkway grating sections are normally fastened to the ties or bridge structure, but during some maintenance activities, the fastenings are removed to permit access to other parts of the bridge structure. When a full, 20-foot section of grating is placed on the outrigger ties, even when one end is not fully supported and the grating has not been fastened down, there is sufficient weight behind the last supporting tie to more than counterbalance the weight of one person that steps on the portion of grating that extends beyond the last support.

In comparison, a hazard is created when shorter sections of grating are placed in such a manner that there may not be sufficient weight to counterbalance a person stepping on a cantilevered portion of grating that is not fastened to the bridge structure. If

this occurs, the end of the grating where a person steps will tilt downward while the opposite end rises, causing both the person and the grating to fall to the surface below. This appears to be what occurred in all three of the incidents described in this safety advisory.

All three of the incidents occurred when bridge work was in progress and the workers involved knew, or should have known, that the grating was not secure. In the case of the subcontractor's employee in Minooka, Illinois, the preliminary investigation suggested that the employee had brought concerns about the unsecured grating to the attention of the general contractor's safety manager prior to the accident. In the other two incidents, information available to FRA suggests that the workers should have been aware that the grating was not secured because it was common practice to keep the grating unsecured until the end of each day or until all the bridge tie replacement was completed for a specific work area. Although each incident contains additional particular facts that suggest other potential contributing causes were factors in the incidents, the preliminary investigations suggest that the injured workers either decided to risk not using a personal fall arrest system or lost sight of the risk in their focus to complete the work. Given that bridge workers are exposed to serious injury or death from a fall, employers should take extra precautions to keep walkway and platform gratings fastened, especially shorter sections of gratings, whenever possible.

Recommended Railroad Action: In light of the foregoing concerns and in an effort to maintain safety on the Nation's railroad bridges, FRA recommends that each railroad, and contractor or subcontractor to a railroad, that employs bridge workers to work on railroad bridges that have walkways or platforms with sections of grating:

- (1) Ensure that the grating be kept fastened, unless immediate work requires unfastening. Once the immediate work is complete, ensure that the fastening is reapplied.
- (2) Ensure that when grating is left unfastened, particularly when sections of grating are shorter than 20 feet, the unfastened grating is identified by marking or signage.
- (3) Ensure that workers on railroad bridges can safely walk around obstacles, such as on-track equipment.
- (4) Employ daily safety briefings with all bridge workers of any craft who may be exposed to the hazard of unsecured grating, and specifically identify the location and nature of the unfastened grating. Such daily safety briefings

should address what fall protection is being provided and remind bridge workers of the likely specific circumstances when a personal fall arrest system is required or advised.

Failure of industry members to take action consistent with the preceding recommendations or to take other actions to ensure bridge worker safety may result in FRA pursuing other corrective measures under its rail safety authority. FRA may modify this Safety Advisory 2011-03, issue additional safety advisories, or take other appropriate action necessary to ensure the highest level of safety on the Nation's railroad bridges.

Issued in Washington, DC, on November 29, 2011.

Jo Strang,

*Associate Administrator for Railroad Safety/
Chief Safety Officer.*

[FR Doc. 2011-31058 Filed 12-2-11; 8:45 am]

BILLING CODE 4910-06-P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

Agency Information Collection Activity Under OMB Review; Reports, Forms and Recordkeeping Requirements

AGENCY: Maritime Administration, DOT.

ACTION: Notice and request for comments.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, this notice announces that the Information Collection abstracted below has been forwarded to the Office of Management and Budget (OMB) for review and approval. The nature of the information collection is described as well as its expected burden. The **Federal Register** Notice with a 60-day comment period soliciting comments on the following collection of information was published on September 8, 2011. No comments were received.

DATES: Comments must be submitted on or before January 4, 2012.

FOR FURTHER INFORMATION CONTACT:

Michael C. Pucci, Maritime Administration, 1200 New Jersey Avenue SE., Washington, DC 20590. Telephone: (202) 366-5167; or Email: Michael.Pucci@dot.gov. Copies of this collection also can be obtained from that office.

SUPPLEMENTARY INFORMATION: Maritime Administration.

Title: Requirements for Eligibility of U.S.-Flag Vessels of 100 Feet or Greater in Registered Length to Obtain a Fishery Endorsement.

OMB Control No.: 2133-0530.

Type of Request: Extension of currently approved collection.

Affected Public: Vessel owners, charterers, mortgagees, mortgage trustees and managers of vessels of 100 feet or greater who seek a fishery endorsement for the vessel.

Forms: None.

Abstract: In accordance with the American Fisheries Act of 1998, owners of vessels of 100 feet or greater who wish to obtain a fishery endorsement to the vessel's documentation are required to file with the Maritime Administration (MARAD) an Affidavit of United States Citizenship and other supporting documentation.

DATES: Comments should be submitted on or before February 3, 2012.

Annual Estimated Burden Hours: 2,950 Hours.

ADDRESSES: Send comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, 725 17th Street NW., Washington, DC 20503, Attention: Maritime Administration Desk Officer. Alternatively, comments may be sent via email to the Office of Information and Regulatory Affairs (OIRA), Office of Management and Budget, at the following address: oira.submissions@omb.eop.gov.

Comments are invited on: Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; the accuracy of the agency's estimate of the burden of the proposed information collection; ways to enhance the quality, utility and clarity of the information to be collected; and ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology. A comment to OMB is best assured of having its full effect, if OMB receives it within 30 days of publication.

Authority: 49 CFR 1.66.

By Order of the Maritime Administrator.

Dated: November 29, 2011.

Julie P. Agarwal,

Secretary, Maritime Administration.

[FR Doc. 2011-31092 Filed 12-2-11; 8:45 am]

BILLING CODE 4910-81-P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket No. MARAD-2011 0149]

Requested Administrative Waiver of the Coastwise Trade Laws: Vessel CHRYSALIS; Invitation for Public Comments

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Notice.

SUMMARY: As authorized by 46 U.S.C. 12121, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below.

DATES: Submit comments on or before January 4, 2012.

ADDRESSES: Comments should refer to docket number MARAD-2011-0149. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. Department of Transportation, Docket Operations, M-30, West Building Ground Floor, Room W12-140, 1200 New Jersey Avenue SE., Washington, DC 20590. You may also send comments electronically via the Internet at <http://www.regulations.gov>. All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at <http://www.regulations.gov>.

FOR FURTHER INFORMATION CONTACT:

Joann Spittle, U.S. Department of Transportation, Maritime Administration, 1200 New Jersey Avenue SE., Room W21-203, Washington, DC 20590. Telephone (202) 366-5979, Email Joann.Spittle@dot.gov.

SUPPLEMENTARY INFORMATION:

As described by the applicant the intended service of the vessel CHRYSALIS is:

Intended Commercial Use of Vessel: "Weekly charter vessel."

Geographic Region: "Florida."

The complete application is given in DOT docket MARAD-2011-0149 at <http://www.regulations.gov>. Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-