IMproving Productivity through Advanced Collaborative Team (IMPACT)

Date
M M • D D • Y Y

○ Day
○ Night

Craft

Location

Project Number

First Name (Optional)

Last Name (Optional)

Company Code

Position | ○ Manager ○ Supervisor ○ Foreman ○ Employee

Company Name (if no code)

CONSTRAINTS

1. Coordination
2. Eng/Design
3. Owner Decision
4. Weather
5. Prerequisite Work
6. Labor
7. Materials
8. Contracts
9. Submittals
10. Approvals
11. Equipment
12. RFIs
13. Site Conditions
14. Inspections
15. Poor Planning
16. Rework
17. Other

8 WASTES

18. Over Production
19. Inventory
20. Waiting
21. Defects
22. Motion
23. Transportation
24. Not Utilizing Resources
25. Skills

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FORM ID 05163525

ALL COMMENTS MUST BE PRINTED IN BLOCK CAPITAL LETTERS

Checklist Reference Number

DESCRIBE THE CONSTRAINT/WASTE AND IMPACT

RECOMMENDED COURSE OF ACTION

IMPACT OF CONSTRAINT ◯ Daily ◯ Weekly ◯ Monthly ◯ Occasionally

PRODUCTION TIME LOST (to the nearest hour)

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