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| **HAZARD REPORT FORM**  CONFIDENTIAL | Date:  Report Ref. No.: |

Note: Pursuant to [ACTIVE LAW OR ORDINANCE ON OFFICE HEALTH AND SAFETY], [COMPANY NAME] employees and visitors are required to report to the human resource management department upon notice of any workplace condition or situation presenting a risk or danger to the premises, employees, and/or visitors. Upon sighting or knowledge of such condition or situation, the employee or visitor must fill out this Hazard Report Form so that company authorities can take action and remedy the hazard immediately.

1. **REPORTING PERSON ☐** EMPLOYEE ☐ VISITOR

**General Information**

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
| Mobile Phone: |  |
| Work Phone: |  |

**If [NAME OF COMPANY] employee:**

|  |  |
| --- | --- |
| Title/Position: |  |
| Department: |  |
| Direct Supervisor: |  |
| Department Head: |  |

1. **ABOUT THE HAZARD**

**What**: Describe the hazard identified?

**When**: Indicate what date and time the hazard was discovered/identified.

**Where**: Indicate the exact location within and around the company premises where the hazard is located.

**Why/How**: Describe or explain how the hazard may negatively affect the surroundings or the people nearby.

|  |  |  |  |
| --- | --- | --- | --- |
| **What** | **When** | **Where** | **Why/How** |
|  |  |  |  |
|  |  |  |  |

1. **RISK ASSESSMENT**

Every hazard should be assessed for the risk it presents to the company's employees, visitors, and premises. Rate the risk based on the following factors: the likelihood of injury, the severity of consequence, and amount of exposure. Place a check (🗸) under the rating that corresponds to your answer. Refer to the legend below.

1 to 2 = Zero to low risk; manageable by routine procedures

3 = Moderate risk; minimize risk by practicable and reasonable controls

4 to 5 = Above average to maximum risk; eliminate the hazard or implement procedures to lessen the risk

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| --- | --- | --- | --- | --- | --- |
| **Consequence** | **1** | **2** | **3** | **4** | **5** |
| First aid only |  |  |  |  |  |
| Serious medical attention |  |  |  |  |  |
| Serious medical attention and rest |  |  |  |  |  |
| Serious injury |  |  |  |  |  |
| Long-term illness |  |  |  |  |  |
| Temporary disability |  |  |  |  |  |
| Permanent disability |  |  |  |  |  |
| Death |  |  |  |  |  |

|  |  |
| --- | --- |
| **Contributing Factors** | **Check Here** |
| Incomplete or no equipment |  |
| Unclear or no procedures |  |
| No training |  |
| Lack of management supervision |  |
| Inefficient management system |  |
| Inappropriate actions/behavior |  |
| Other, specify: |  |

1. **RECOMMENDATIONS**

Provide recommendations on what to do with the hazard. An appropriate person must be consulted with when filling out this portion of the form. A corrective action plan will be based on the answers in this portion.

**Types of Hazard Controls**

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ | Elimination | ☐ | Engineering |
| ☐ | Substitution | ☐ | Administration |
| ☐ | Isolation | ☐ | Personal Protective Equipment |

**Specific Actions to be taken**

**What:** Name the action/procedure to be taken against the hazard

**When:** Date and time of the planned implementation

**Who:** Persons involved in implementing the action/procedure

**How:** Describe the steps in implementing the action/procedure

|  |  |  |  |
| --- | --- | --- | --- |
| **What** | **When** | **Who** | **How** |
|  |  |  |  |
|  |  |  |  |

**RECEIVED BY:**

Name:

Date:

Signature: