

Workplace Hazard – Corrective Action Report

Department of Facilities Management Occupational Health and Safety

Occupational mealth and Sale	Ly	
1. Date of Report:	Time: a.m. or p.m.	2. Name of Employee:
3. Service:	unin or pinn	4. Name of Supervisor:
		4. Name of Supervisor.
Shop:	 	
5. Check one of the following to indicate the type of report.		
	ployee Concern	Refusal to Work
6. Was anyone injured? Yes No		
Was equipment, property or facilities damaged? Yes No		
Did this situation involve an incident or near miss? Yes No		
7. Location:		
8. Description of the Hazard, Concern or the Reasons for a refusal to Work:		