**Department Inspection Form**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Area or Department Name)

Responsible manager or supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Inspection conducted by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If there have been injuries or near misses, be sure to focus attention on preventing them from happening again.*

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| --- | --- |
| Indicate priority of items needing attention  1 = Low priority | 2 = Medium priority | 3 = High priority (Circle any IMMINENT DANGER items) | |
| **CHECK ITEMS NEEDING ATTENTION** | **DESCRIBE DEFICIENCIES NOTED AND ACTIONS REQUIRED** |
| WALKING AND WORK SURFACES   * Housekeeping * Aisles * Exits * Work surfaces * Stairs and Ladders * Other |  |
| MACHINERY   * Point-of-operation guarding * Barriers and gates * Interlocks * Lockout tagout * Other |  |
| ELECTRICAL   * Panel clearance maintained * Circuits marked * Extension cords * Grounding and GFCI * Other |  |
| CHEMICAL   * SDSs available and organized * Container labeling * Storage and arrangement * Flammables in approved safety containers and cabinets * Any spillage or leakage * Cylinders secured * Other |  |
| Indicate priority of items needing attention  1 = Low priority | 2 = Medium priority | 3 = High priority (Circle any IMMINENT DANGER items) | |
| **CHECK ITEMS NEEDING ATTENTION** | **DESCRIBE DEFICIENCIES NOTED AND ACTIONS REQUIRED** |
| ENVIRONMENTAL   * Airborne contaminants * Ingestion hazards * Skin contact * Noise * Temperatures * Illumination * Ventilation * Personal Protective Equipment * Other |  |
| ERGONOMICS   * Awkward postures * Repetitive motion * Forceful exertions * Contact pressure * Work station design * Other |  |
| UNSAFE BEHAVIORS   * Horseplay * Unsafe lifting * Improper tool use * Bypassing safety devices * Not using PPE * Risk taking in general * Other |  |
| AREA SPECIFIC HAZARDS   * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |