Step #2

WORKPLACE HAZARD ASSESSMENT CORRECTIVE ACTION

Company Name:

Assessment Location (s): | Time/Date:

Department/Areas Covered:

Assessment Team: Name _____ Position _____

_____ _____

			FOLLOW-UP	
ITEM#	PRIORITY	RECOMMENDED ACTION	ACTION TAKEN DATE/TIME	BY WHOM

COPIES TO: (FOR ACTION) (FOR INFORMATION):

Manager's Signature: Date: