Capital Health

Workplace Safety Inspection Report

Date: **Department:**

Site: **Building:** **Floor:** **Area:**

Inspection by: Name: Position: Telephone:
Name: Position: Telephone:

The following deficiencies were noted:

Description	Location	Hazard Class			Recommended Action	Assigned To:	Action Completed Date
		A	B	C			

Narrative/Comments:

Include areas/rooms Inspected with no deficiencies.

Please forward a copy of the Signed report to: Director/Manager: ____________________ Inspection Team: ____________________
JOHSC or Workplace Safety Team