

Department Inspection Form

_____ (Area or department name)

Responsible manager or supervisor: _____ Date: _____

Inspection conducted by: _____

Indicate priority of items needing attention. <small>1 = Low priority 2 = Medium priority 3 = High priority (Circle any IMMEDIATE DANGER items.)</small>	
CHECK ITEMS NEEDING ATTENTION.	DESCRIBE DEFICIENCIES NOTED AND ACTIONS REQUIRED.
WALKING AND WORK SURFACES <input type="checkbox"/> Housekeeping <input type="checkbox"/> Aisles <input type="checkbox"/> Exits <input type="checkbox"/> Work surfaces <input type="checkbox"/> Stairs and ladders <input type="checkbox"/> Other	
MACHINERY <input type="checkbox"/> Point-of-operation guarding <input type="checkbox"/> Barriers and gates <input type="checkbox"/> Interlocks <input type="checkbox"/> Lockout tagout <input type="checkbox"/> Other	
ELECTRICAL <input type="checkbox"/> Panel clearance maintained <input type="checkbox"/> Circuits marked <input type="checkbox"/> Extension cords <input type="checkbox"/> Grounding and GFCI <input type="checkbox"/> Other	
CHEMICAL <input type="checkbox"/> MSDSs available and organized <input type="checkbox"/> Container labeling <input type="checkbox"/> Storage and arrangement <input type="checkbox"/> Flammables in approved safety containers and cabinets <input type="checkbox"/> Any spillage or leakage <input type="checkbox"/> Cylinders secured <input type="checkbox"/> Other	

