GLENN COUNTY
EMPLOYEE REPORT OF UNSAFE CONDITION OR HAZARD FORM

EMPLOYEE INFORMATION

Name: (Optional)	Title:	Date:
Department:	Phone Number	
Supervisor's Name:	Dept. Safety Representative:	

HAZARD CLASSIFICATION

- ❑ Near Miss
- ❑ Safety/Health Concern
- ❑ Unsafe Condition
- ❑ Unsafe Act or Practice
- ❑ Operational Concern
- ❑ Other: _____

Location:	
Date	Time:
Describe unsafe condition or hazard:	
What corrective action would you recommend (if any)?	
Employee Signature:	Date:

WITNESS INFORMATION

Name of Witnesses (if any):	
Name:	Phone #:
Name:	Phone #:
Name:	Phone #:

INVESTIGATION COMPLETED BY

Name:	Date:
Title:	Phone #:

Results of investigation:	
Identify the cause(s) of the incident	
Signature:	Title:

CORRECTIVE ACTION INFORMATION

What corrective action has been taken or is recommended to prevent a recurrence of a similar accident?	
Has corrective action been completed? Yes ☐ No☐	If yes, date completed:
If no, please give reason:	
Person Responsible for implementing corrective action:	Phone Number:
Department Safety Representative Signature:	Date:
Department Head Signature:	Date:

Copies to:

Department Office
County Asst. Safety Officer