

HEALTH AND SAFETY HAZARD REPORT

NAME: _____ DATE: _____
DEPARTMENT: *Aviation* PHONE: _____

SAFETY HAZARD: _____

WHY DO YOU FEEL THIS IS A HAZARD?

REQUESTED SOLUTION TO THE PROBLEM:

SUBMIT COMPLETED FORM TO IMMEDIATE SUPERVISOR

SUPERVISOR RESPONSE

DATE RECEIVED: _____ SUPERVISOR'S NAME: _____ PHONE: _____

COMMENTS: _____

IF A HAZARD DOES EXIST, WHAT IS YOUR PLAN OF ACTION TO RESOLVE IT? (PLEASE INCLUDE A TIME FRAME)

SEND ORIGINAL TO DEPARTMENT HEAD AND A COPY TO THE EMPLOYEE WITHIN 10 WORKING DAYS OF RECEIPT OF THIS FORM

DEPARTMENT HEAD RESPONSE

DATE RECEIVED: _____ SIGNATURE: _____ PHONE: _____

COMMENTS: _____

ACTION TO BE TAKEN: _____

**SEND ORIGINAL TO THE CLARK COUNTY RISK MANAGEMENT OFFICE AND A COPY TO THE EMPLOYEE AND SUPERVISOR
WITHIN 10 WORKING DAYS OF RECEIPT OF THIS FORM**

CLARK COUNTY
SAFETY OFFICER SIGNATURE: _____ DATE: _____

HEALTH AND SAFETY COMMITTEE

COMMENTS: _____

