KLAMATH COUNTY
EMPLOYEE REPORT OF UNSAFE CONDITION OR HAZARD FORM

EMPLOYEE INFORMATION (OPTIONAL):

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

HAZARD CLASSIFICATION

D Near Miss

D Safety/Health Concern

D Unsafe Condition

D Unsafe Act or Practice

D Operational Concern

D Other: ______________________________

Location of Hazard:	
Date the condition or hazard was observed:	Date and time the condition or hazard was observed:
Describe unsafe condition or hazard:	
What corrective action would you recommend (if any)?	
Employee Signature (Optional):	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:

County Risk Management

Department Supervisor