

Occupational Medicine Clinic

Work Site Evaluation Form		
Survey Date:		Time Spent:
Workplace:		Location:
Workplace Supervisor:		Phone #:
E-mail:		
ADMINISTRATIVE:		
1. IH Identified Hazards & Medical Surveillance (List):		
2. Description of Operations and Major Tasks (describe service or finished product, how many staff):		
3. Reproductive Hazards list:		
1. Industrial Hygiene Survey Surveillance Recommendations:		

Employee Concerns:
Findings and Observations (Use of correct PPE, followed previous recommendations, etc.):
Teaching/Training Provided:
Recommendations:
Follow up Recommended:
Evaluator (Print Name):