

HAZARD ASSESSMENT

ACCIDENT PREVENTION: STOP, THINK, THEN ACT...			
Employee Name:		Date:	
Project:			
Am I Auditing Someone Else? <input type="checkbox"/> Y <input type="checkbox"/> N		If Yes Who? Worker Name	
Nature Of Intervention:		Area/Equipment:	
PROCEDURES/POLICIES			
<input type="checkbox"/> WORK AREA		<input type="checkbox"/> EXCAVATION	
<input type="checkbox"/> CONFINED SPACE		<input type="checkbox"/> FIRE PROTECTION OFFLINE	
<input type="checkbox"/> HOT WORK PERMIT		<input type="checkbox"/> OTHER (Specify):	
PERSONAL PROTECTIVE EQUIPMENT			
<input type="checkbox"/> HARD HAT		<input type="checkbox"/> TYVEK COVERALL	
<input type="checkbox"/> SAFETY GLASSES		<input type="checkbox"/> DUST MASK	
<input type="checkbox"/> GLOVES		<input type="checkbox"/> APROPRIATE RESPIRATOR	
<input type="checkbox"/> HEARING PROTECTION		<input type="checkbox"/> HI-VIS VEST	
<input type="checkbox"/> PROTECTIVE VISOR		<input type="checkbox"/> SAFETY HARNESS	
<input type="checkbox"/> SAFETY BOOTS		<input type="checkbox"/> RUBBER BOOTS (CSA APPROVED)	
<input type="checkbox"/> CHAIN SAW PANTS		<input type="checkbox"/> OTHER (Specify):	
POTENTIAL HAZARDS ASSOCIATED WITH THE SCOPE OF WORK			
Risk Of Slipping Or Tripping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk Of Falling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk Of Sprain (Pushing, Pulling, Lifting)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Presence Of Hazardous Materials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk Of Fire Or Explosion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk Of Electrocutation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk Of Getting Caught In Or Between?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk Of Getting Stuck By Or Against?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sufficient Work Space?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sharp Edges?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blind Work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk Of Falling Material?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk Of Material Being Ejected?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Need A Safety Barricade?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotating Equipment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alley Or Work Area Without Obstruction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adequate Tools And Tools Grounded?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
POTENTIAL HAZARDS ASSOCIATED WITH THE SCOPE OF WORK			
Enough Storage Room For Tools?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enough Employees To Perform Work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adequate Ventilation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adequate Lighting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Risk Of Burns Or Frostbite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE OF WORK AREA	YES	NO	N/A
Area Clean And In Good Order?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Presence Of Fumes Or Gases?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Presence Of Dust?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extreme Temperature?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAS EVERYTHING POSSIBLE BEEN DONE TO MAKE THE WORK SAFE?			
Suggestions/Comments/Corrections:			
SUPERVISOR REVIEW			
Name:	Signature:	Date:	
SUPERINTENDENT REVIEW			
Name:	Signature:	Date:	
FOLLOW UP BY (If required)			
Worker Name:	Signature:	Date:	
Notes:			