ODNR Health and Safety Complaint Form

Employee Name: _____ Date:_____

Employee's Classification: _____

Work Location: _____

Supervisor Notified: _____Date:_____

Did Injury Occur: Yes _____ No _____ If Yes Explain:_____

Name and Location of Safety Hazard: _____

_____

_____

_____

Employee's Suggestion for Remedy if Any:_____

_____

_____

_____ _____

Signature of Employee Date

_____ _____

Signature of Supervisor Accepting Complaint Date

<u>For Supervisor Use Only</u>

Party Notified of Corrective Action is Warranted: _____

Corrective Action Taken: _____ Date: _____

Comments: _____

_____

_____

_____

_____ _____

Signature of Supervisor Date

To be completed and returned to the Office of Human Resources within 3 working days.

ODNR-OHR, 2045 Morse Road, Bldg. D-1, Columbus, Ohio 43229

Fax 614-265-7995