

Department of Natural Resources

HEALTH AND SAFETY COMPLAINT FORM

Employee's Name: _____ Date: _____

Employee's Classification: _____

Work Location: _____

Supervisor Notified: _____ Date: _____

Did Injury Occur: _____ If Yes Explain: _____

Nature and Location of Safety Hazard: _____

Employee's Suggestion for Remedy if Any: _____

Signature of Supervisor
Accepting Complaint

Signature of Employee

For Supervisor Use Only

Party Notified of Corrective Action if Warranted: _____

Corrective Action Taken: _____ Date: _____

Comments: _____

Signature of Supervisor

Date

To be completed and returned to the Labor Relations Section within three (3) working Days.
1930 Belcher Dr. Building D-1 Columbus, Ohio 43224