**complaints submission form**

FRM-002-2

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of incident:** |  | / |  | / |  |  | **Time:** |  | : | (am/pm) | |
| **Name of person reporting:** | | |  | | | | | | | |
| **Date reported:** |  | / |  | / |  |
| **Witnesses (if any):** |  | | | | |  |  |  |  | | |
|  |  | | | | |  |  |  |  | | |

**COMPLAINT DETAILS**

|  |
| --- |
| **Location of the incident:** |
|  |
| **Person/s involved:** |
|  |
| **Description of incident:** |
|  |
| **What factors contributed to the incident or hazard?** |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |

**FOR OFFICE USE ONLY**

|  |  |  |  |
| --- | --- | --- | --- |
| **RECOMMENDED ACTION** | | | |
| **NO.** | **ACTION DESCRIPTION** | **BY WHOM** | **BY WHEN** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **COMPLAINT REVIEW AND SIGN OFF** | | | |
| **ROLE** | **NAME** | **SIGNATURE** | **DATE** |
| Person/s involved |  |  |  |
| Immediate Supervisor |  |  |  |
| Work Health and Safety Manager / Coordinator |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **EVALUATION** | **COMMENT** | **CONDUCTED BY** | **DATE** |
| *(TO BE CONDUCTED 3 MONTHS AFTER INCIDENT OCCURRENCE)* | | | |
| Have all corrective actions been implemented? |  |  |  |
| Has the incident and corrective actions been communicated to personnel and key stakeholders? |  |  |  |
| Have any similar incidents or near misses occurred? |  |  |  |
| Do the implemented controls appear to be effective? |  |  |  |

**SIGN-OFF**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Name of person reporting |  | Signature |  | Date |
|  |  |  |  |  |
| Supervisor’s name |  | Signature |  | Date |
|  |  |  |  |  |
| Manager’s name |  | Signature |  | Date |