

**Weekly Eyewash Inspection**

Location \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_

**1) Items to check.**

- |                                                   |                                                    |
|---------------------------------------------------|----------------------------------------------------|
| a) Is weekly flush done? _____Yes _____No         | c) Are there any leaks? _____Yes _____No           |
| <b>2) Visual function test.</b> _____Yes _____No  | d) Any broken parts? _____Yes _____No              |
| a) Is it clean? _____Yes _____No                  | e) Is there appropriate pressure? _____Yes _____No |
| b) Are protective caps in place? _____Yes _____No |                                                    |

Comments: \_\_\_\_\_

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