



MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA

PROGRAM FOR OCCUPATIONAL HEALTH AND SAFETY

1. Name of the Institution: _____
2. Address: _____
3. City: _____ State: _____ Pin: _____

4. Name of the Employer: _____
5. Address: _____
6. City: _____ State: _____ Pin: _____
7. Name of the Manager: _____
8. Designation: _____
9. Name of the Supervisor: _____
10. Designation: _____

11. Name of the Worker: _____
12. Designation: _____
13. Address: _____
14. City: _____ State: _____ Pin: _____
15. Name of the Employer: _____
16. Designation: _____
17. Name of the Supervisor: _____
18. Designation: _____

DECLARATION

I hereby declare that the above information is true and correct.

Signature of the Manager
Signature of the Supervisor
Signature of the Worker

For the Manager: _____
For the Supervisor: _____
For the Worker: _____