

# Request for a Health Hazard Evaluation

Form Approved  
OMB No. 0920-0260  
Exp. Xx/xx/20xx

This form also is available at <http://www.cdc.gov/niosh/hheform.html>

Workplace Name \_\_\_\_\_

Workplace Address \_\_\_\_\_  
Street City State Zip Code

What type of work is done **at this location**? \_\_\_\_\_

How many people work **at this location**?

3 or less     4-9     10-49     50-99     100-249     250 or more

Who is responsible for employee health and safety in this workplace?

Name \_\_\_\_\_ Title \_\_\_\_\_ Phone number \_\_\_\_\_

What hazardous substances, agents, or work conditions are of concern? If known, please include chemical names, trade names, manufacturer name, or other identifying information.

How are employees exposed?

Breathing     Skin Contact     Swallowing     Other (Explain : \_\_\_\_\_)

In what work area, such as a building or department, is the hazard? \_\_\_\_\_

How many people work in **this area**?

3 or less     4-9     10-49     50-99     100-249     250 or more

Describe the work people do in this area: \_\_\_\_\_

What health concerns do people in this work area have? \_\_\_\_\_

## Information about you

Name (please print): \_\_\_\_\_

Your signature: \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Phone number where you would like to be called: (\_\_\_\_) \_\_\_\_\_

Best time to call: \_\_\_\_\_ a.m. or p.m.

Email address where you would like to be contacted: \_\_\_\_\_

Please check one:

I am a current employee and 3 or fewer employees are exposed to the hazard.

I am a current employee and more than 3 employees are exposed to the hazard.

\*If you check this box, two other employees need to sign this form and provide their contact information.

## Second employee

Name (Please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Phone number where you would like to be called: (\_\_\_\_) \_\_\_\_\_

Best time to call: \_\_\_\_\_ a.m. or p.m.

Email address where you would like to be contacted: \_\_\_\_\_

Can NIOSH reveal your name to the employers?  No  Yes

## Third Employee

Name (Please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Phone number where you would like to be called: (\_\_\_\_) \_\_\_\_\_

Best time to call: \_\_\_\_\_ a.m. or p.m.

Email address where you would like to be contacted: \_\_\_\_\_

Can NIOSH reveal your name to the employers?  No  Yes

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## Complete this section if you are a union representative

Name of union: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

What is your position in the union: \_\_\_\_\_

## Complete this section if you are an employer representative

Name: \_\_\_\_\_

What is your position in the company, agency, or organization? \_\_\_\_\_

## For everyone

Has another government agency evaluated this workplace?  No  Yes  Do not know

If yes:

What agency? \_\_\_\_\_

What year was the evaluation done? \_\_\_\_\_

Check here if this evaluation is underway now

Is a request for the hazard being filed with another agency?  No  Yes  Do not know

If yes:

What agency? \_\_\_\_\_

How did you learn about the NIOSH Health Hazard Evaluation Program?

NIOSH website  Facebook  other website (Explain : \_\_\_\_\_)

CDC 1-800 number  Union  Coworkers  Company official

trade/industry/union magazine or newsletter  Other (Explain : \_\_\_\_\_)

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If you have questions about this form, call us at (513) 841-4282 or send us an email at [HHERequestHelp@cdc.gov](mailto:HHERequestHelp@cdc.gov).

To submit this form by fax, send it to (513) 841-4488.

To submit this form by mail, send it to: National Institute for Occupational Safety and Health  
4676 Columbia Parkway, MS R-9  
Cincinnati, Ohio 45226

**Thank you for submitting this form. You will get a response from us within 10 days.**