**Self-evaluation questionnaire**

**for health and safety management systems certification**

(Annex to the Official Application for certification)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| GENERAL INFORMATION | | | | | | | |
| Organization: | | | | | | | |
| Contact person for the audit | | Name: | | | | | |
| Telephone: | | | | | |
| Management representative for the Health and Safety Management System | | Name: | | | | | |
| Telephone: | | | | | |
| Does the organization have equipment/ installation that require special protection measures? | | | | Yes |  | No |  |
| If Yes please describe: | | | | | | | |
| Does the organization use hazardous chemical substances? | | | | Yes |  | No |  |
| If Yes please describe: | | | | | | | |
| Does the organization use special health and safety protection equipment? | | | | Yes |  | No |  |
| If Yes please describe? | | | | | | | |
| Does the organization use work on height? | | | | Yes |  | No |  |
| Does your organization (sub)contracts activities to external suppliers? | | | | Yes |  | No |  |
| If Yes, please name these activities and the no. of personnel/ activity: | | | | | | | |
| Was the occupational health and safety risk assessment performed? | | | | Yes |  | No |  |
| In the last 3 years were there recorded work accidents or professional illnesses? | | | | Yes |  | No |  |
| If Yes please describe: | | | | | | | |
| Technological and legal context of the organization: | Advanced technology | | | Yes |  | No |  |
| High degree of regulation | | | Yes |  | No |  |
| High no. of unique activities | | | Yes |  | No |  |
| Do the processes differ from shift to shift? | | | | Yes |  | No |  |
| If Yes, please mention the processes on each shift: | | | | | | | |
| Types of main processes: | Repetitive processes | | Unique processes | | | | |
|  | |  | | | | |
| Please mention the location and no. of personnel of contractors: .......... | | | | | | | |
| Please mention the location and no. of personnel of subcontractors: .............. | | | | | | | |
| What is the structure of the employees/ jobs? (*fill in for head office and each location, either permanent or temporary, addresses where you perform support activities for the certification scope – warehouse, laboratory, repair shop, offices, etc)* | | | | | | | |
| Address | Job (locksmith, turner, etc) | | No. of employees | | | | |
|  |  | |  | | | | |

In case it is considered necessary CERTIND can request for supplementary information regarding the management system.

CERTIND is bound to confidentiality over the information provided by the organization.

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorized representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

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