

EMERGENCY EQUIPMENT TESTING LOG



Location of Emergency Equipment: _____

Department/Facility: _____ **P.I. Responsible for Unit:** _____

Please check Type of Equipment:

- Eye Wash Station**
 Emergency Shower
 Combination Eye Wash/Shower
 Drench Hose
- *At minimum, eye wash are to be tested weekly and emergency shower monthly. See Program Manual for details.*
 - *The testing logs need to be located within the facility at each station and made available for inspection or upon request.*

Testing Date	Signature of person completed the testing	Testing Date	Signature of person completed the testing

