

Overnight Experiment/Reaction Form

Research Group

Date:

Name of Researcher:

Contact number:

Left Hotplate:

Middle Hotplate:

Right Hotplate:

Possible Hazards:

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Very Toxic/Toxic | <input type="checkbox"/> Corrosive | <input type="checkbox"/> Mutagen/teratogen |
| <input type="checkbox"/> Harmful/Irritant | <input type="checkbox"/> Explosive | <input type="checkbox"/> Radiation hazard |
| <input type="checkbox"/> Flammable | <input type="checkbox"/> Lachrymator | <input type="checkbox"/> Biohazard |
| <input type="checkbox"/> Oxidising agent | <input type="checkbox"/> Stench | <input type="checkbox"/> UV |
| | <input type="checkbox"/> Carcinogenic | <input type="checkbox"/> Other (specify): |

Services required:

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Water | <input type="checkbox"/> Inert gas |
| <input type="checkbox"/> Electricity | <input type="checkbox"/> Vacuum |
| <input type="checkbox"/> Heating | <input type="checkbox"/> Other (please specify): |

Emergency actions:

Spillage:

Fire (state extinguisher type or sand):