

Daily Room Safety Inspection Log

Date:

Room/Area:

Inspected by:

No.	Inspection Item	Pass	Fail	Comments/Actions Required
1	<input type="text" value="E.g., Doors & Windows Secure"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="Enter comments"/>
2	<input type="text" value="E.g., Fire Exits Clear"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="Enter comments"/>
3	<input type="text" value="E.g., Electrical Hazards Absent"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="Enter comments"/>
4	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
5	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Inspector's Signature: _____