



WORK ENVIRONMENT MEASUREMENT (WEM) REQUEST

- Print/write **LEGIBLY**.
- Mark appropriate boxes with “✓”.
- Write “**NONE**” if not present or not existing in the company.
- **Incomplete request form will not be processed and be sent back to the company’s email address. Please do not leave any unanswered items.**

Date of Application: _____		
Company Name: _____	Address: _____	Region _____
Email address: _____		
Tel./Fax No: _____		
Type of Industry/Nature of Business (<i>Pls. specify</i>)	Number of Workers (including outsource personnel): Male: _____ Female: _____ Total: _____	
<input type="checkbox"/> Manufacturing of _____	Risk Classification: <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	
<input type="checkbox"/> Service/s _____		
<input type="checkbox"/> Others _____		
Name of Safety Officer(s):	<input type="checkbox"/> Safety Officer 1 <input type="checkbox"/> Safety Officer 3 <input type="checkbox"/> Safety Officer 2 <input type="checkbox"/> Accredited Safety Officer 3 <input type="checkbox"/> Safety Officer 4	
Purpose of WEM Request		
<input type="checkbox"/> Workplace Improvement <input type="checkbox"/> OSHS Compliance <input type="checkbox"/> Required by Labor Inspector <input type="checkbox"/> Client/Customer Requirement <input type="checkbox"/> ISO Compliance (attach notice of inspection report) <input type="checkbox"/> Others: <i>Specify</i> _____		
WEM Internal Monitoring Capability	WEM Equipment owned by company: _____	Conducting internal WEM? <input type="checkbox"/> Yes Date of Internal Monitoring _____ Name of Personnel who conducted WEM _____ <input type="checkbox"/> No _____
WEM Conducted by:		
<input type="checkbox"/> OSHC Date of last WEM: _____ <input type="checkbox"/> Accredited WEM Provider : _____ Date of last WEM: _____ Conducted by: _____ <input type="checkbox"/> None (New Client)		
Note: Please attach improvements initiated / administered based on WEM recommendations		
Please select the parameters to be measured per work area based on the initial assessment of the Safety Officer:		
A. Physical Hazards		
<input type="checkbox"/> Noise <input type="checkbox"/> Vibration <input type="checkbox"/> Illumination <input type="checkbox"/> Heat		
B. Chemical Hazards		
<input type="checkbox"/> Dust <input type="checkbox"/> Heavy Metals <input type="checkbox"/> Organic Solvents <input type="checkbox"/> Acids <input type="checkbox"/> Gases <input type="checkbox"/> Others: <i>Specify</i> _____		
C. Ventilation		
<input type="checkbox"/> General Ventilation <input type="checkbox"/> Local Exhaust Ventilation		
<i>This is to certify that the company agrees to pay all the expenses incurred during coordination and other pre-WEM activities such as communication, consumables, transportation expense, etc. in the event that the company cancels the WEM on/or 5 working days before the scheduled WEM.</i>		
<i>By filling out this form and signing below, I am giving my consent to the OSHC to collect, process, retain and store my personal data in accordance with the provisions of Republic Act 10173 – Data Privacy Act of 2012.</i>		
_____ Signature over Printed Name of Requesting Personnel		_____ Position / Designation

Instructions:

Please send the signed and fully accomplished WEM Request Form to the email address below:

To: oed@oshc.dole.gov.ph
oed.oshc@gmail.com

Cc: ecd.oshc.wem@gmail.com (dedicated email for WEM request)

Or Fax to: (632) 8929-60-30; (632) 8924-24-12

If faxed, please notify us through the email addresses provided above for proper acknowledgement. Otherwise request will not be processed.

Please address the email to:

Noel C. Binag, CE
Executive Director
Occupational Safety and Health Center
Department of Labor and Employment