

Client Safety Observation Sheet

Date:	<input type="text"/>
Time:	<input type="text"/>
Client Name:	<input type="text"/>
Room/Location:	<input type="text"/>
Observed By:	<input type="text"/>

Observation Details

Area of Observation	Safe	Unsafe	Comments
Room Environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Client Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Emergency Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Additional Notes

Submit