County of San Bernardino
Department of Behavioral Health

Safety Concern Report

Date/Time:	Name of LSC:	Location:	Clinic Supervisor: Program Manager:	Phone #:

Nature of Concern:

Previous Action Taken to Resolve:

Previously reported to safety committee? YES ☐ NO ☐ Reason:	Safety Officer Action on date of report:	Follow Up Action: DATE:	Follow Up Action: DATE:

Unsafe condition corrected/resolved (DATE:)

If unable to resolve, please state reason:

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