



भारत सरकार
विज्ञान और प्रौद्योगिकी मंत्रालय
विज्ञान और प्रौद्योगिकी विभाग
GOVERNMENT OF INDIA
MINISTRY OF SCIENCE & TECHNOLOGY
Department of Science & Technology

Study Conducted by:



NATIONAL FOUNDATION OF
INDIAN ENGINEERS

Study to Assess Occupational Health Hazards for Woman Workers in Readymade Garments, Plastic Products & Electronic Assembly Industry in India and Preparation of Manuals there to

Supported & Catalyzed by:

RASHTRIYA VIGYAN EVAM PRODYOGIKI SANCHAR PARISHAD (RVSP), Government of India

Please read the instructions before filling the questionnaire

1. Please attach extra sheets wherever required.
2. No inter organization/ inter employee comparisons will be carried out and information will be kept secret and will not be disclosed to any one. Analysis will be carried on the overall basis sector/industry wise.
3. If any particular item is not applicable in your case, please leave it blank.

QUESTIONNAIRE FOR OWNERS

1.	Name of the Owner:			
2.	Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
	Age (in years):	<input type="text"/> <input type="text"/>		
3.	Year of Establishment of the Organization	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
4.	Name of the Organization:			
5.	Communication address of the Organisation:			
	City			
	State			
	Pin Code		Phone	
	Mobile		Fax	
	E-mail		Website	
6.	Are you providing training to your employees for various components of job including safety measures? <input type="checkbox"/> Yes <input type="checkbox"/> No			
7.	What are the occupational hazards in your organization? (Pl. \sqrt mark)			
	Type of Hazards	Yes	No	Cannot Say
	Physical Hazards			
	a) Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) Noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) Vibration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e) Unsatisfactory Lighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f) Any Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chemical Hazards			
	a) Dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) Fumes / Gases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) Any Chemical Exposure reflecting on human health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) Any Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Man Machine Relationship Hazards			
	a) Fatigue / Exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) Any Chronic Developments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) Any Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Type of Hazards		Yes	No	Cannot Say	
Accidents					
a)	Electrical Burns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b)	Gas Burns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c)	Hot Water Burns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d)	Falls from Height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e)	Slipping the Floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f)	Cuts from Plant & Tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g)	Cuts from Broken Glass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
h)	Collapse of Lifting Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
i)	Any Other (Pl. specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	What are the provisions/ systems of safety in your organization for avoiding the occupational hazards? (Please ✓ tick mark)				
	<input type="checkbox"/> Availability of Functional First Aid Box	<input type="checkbox"/> Helmets			
	<input type="checkbox"/> Availability of Functional Exhaust Fans	<input type="checkbox"/> Proper & Regular cleaning of the shop floor			
	<input type="checkbox"/> Proper electrical system with earthing	<input type="checkbox"/> Proper railing of the stairs			
	<input type="checkbox"/> Protective clothing	<input type="checkbox"/> Adequate moving space around the working machines			
	<input type="checkbox"/> Gas Protective Masks	<input type="checkbox"/> Adequate moving space in other areas			
	<input type="checkbox"/> Protective Machine Guards	<input type="checkbox"/> Adequate clean water drinking facility			
	<input type="checkbox"/> Safety Goggles	<input type="checkbox"/> Adequate vehicle safety for movement			
	<input type="checkbox"/> Safety Hand Gloves	<input type="checkbox"/> Safety devices from movement of machines like conveyer belts and hydraulic lifting machine			
	<input type="checkbox"/> Protective Shoes/ Gumboots				
9.	Do your workers work over time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
10.	Are safety / danger sign boards displayed at convenient places at your works?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
		Average	Good	Very Good	Excellent
11.	What is the over all status of house keeping / hygiene at your work place?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	In your view, what is the standard of overall management of health and safety at work place?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	What is the status of system of accidents handling in your organization?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Yes	No
14.	Do you have a system of handling sexual harassment problems in your organization			<input type="checkbox"/>	<input type="checkbox"/>
15.	Do you have a work policy in your organization for expectant and new mothers?			<input type="checkbox"/>	<input type="checkbox"/>
16.	Do you have various welfare facilities in your organization?			<input type="checkbox"/>	<input type="checkbox"/>
17.	Do you have a system for the accident investigations in your organization?			<input type="checkbox"/>	<input type="checkbox"/>
18.	Is smoking allowed at the work place?			<input type="checkbox"/>	<input type="checkbox"/>
19.	Is mobile phone allowed at the work place?			<input type="checkbox"/>	<input type="checkbox"/>
20.	Is there any employee safety hand book available in your organization?			<input type="checkbox"/>	<input type="checkbox"/>
	If Yes	<input type="checkbox"/> In English	<input type="checkbox"/> In Hindi	<input type="checkbox"/> In local Regional Language	
21.	Is there any provision for compensation to workers for occupational related injuries / diseases?			<input type="checkbox"/>	<input type="checkbox"/>
22.	Is there facility of complaint book / box in your organization?			<input type="checkbox"/>	<input type="checkbox"/>
23.	Are complaints attended to promptly in your organization?			<input type="checkbox"/>	<input type="checkbox"/>
24.	Are there provisions of medical facilities in your organization?			<input type="checkbox"/>	<input type="checkbox"/>
	If Yes	<input type="checkbox"/> Doctor / Nurse on Call	<input type="checkbox"/> First Aid Box		
25.	Whether any safety drills are conducted in the organization?			<input type="checkbox"/>	<input type="checkbox"/>

26.	What additional health & safety measures you would suggest?		
27.	Any other information you would like to give relating to occupational hazards & safety improvement in your organization.		
<table border="1"> <tr> <td style="width: 50%; vertical-align: top;"> Place: _____ Date: _____ </td> <td style="width: 50%; vertical-align: bottom; text-align: center;"> (Signature of the Respondent) </td> </tr> </table>		Place: _____ Date: _____	(Signature of the Respondent)
Place: _____ Date: _____	(Signature of the Respondent)		

Thanks for sparing your valuable time and filling in the questionnaire. Your data will definitely help for us to prepare the report in time.

Please send the filled in Questionnaire at the following address:

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