Therapy Safety-System Checks

FORM 37

Facility Name: _____ **Period(s) or Date(s):** _____ **Sheet:** _____

Unit or Energy Class: _____ **Procedure or Hours or Next Due:** _____

Test interlocks, warnings, and safety devices at the equipment-specific frequency; document failures and corrections.

Date	Interlock or Warning or Safety Device	Test or Result	Service or Corrective Action or Verification	Performed By

Therapy Safety-System Checks

Facility Name: _____ **Period(s) or Date(s):** _____ **Sheet:** _____

Record supporting references, review, and applicable requirements below.

Note(s) or Supporting Record(s):

Reviewed By: _____ **Review Date:** _____

State or Jurisdiction: _____

Regulatory Requirement Reference(s): _____

Required Interval(s) or Deadline(s): _____

Retention(s) or Trigger(s): _____