Waste Management Practice Assessment Sheet

Site/Location:

Date:

Assessor Name:

Department/Area:

Assessment Criteria

Criteria	Yes	No	Comments
Waste properly segregated?	☐	☐	
Waste containers labeled correctly?	☐	☐	
Containers in good condition?	☐	☐	
Storage area clean and organized?	☐	☐	
Spill kits available and accessible?	☐	☐	
Regular waste removal scheduled?	☐	☐	

Findings & Recommendations

Assessor Signature:

Date: