FACILITIES MANAGEMENT

FM SAFETY SHOE REQUEST FORM

All safety shoes must be rated in accordance with ASTM 2413-18, or equivalent, to meet compression (75), impact (75) and electrical hazard (EH) specifications.

TO: Facilities Management (FM) Human Resources/Safety & Health Office

FROM: _____

Employee's Name – Please Print

Employee Unit/Shop:_____

Employee Job Title: _____

1. Has FM supplied you with Safety Shoes before? **Yes** ☐ **No** ☐

2. Choose the reason for your safety shoe request:
   - ☐ **Poor Fit**
   - ☐ **Worn Out**
   - ☐ **Boots Leaking**
   - ☐ **Other**_____

3. How often do you wear your safety shoes:
   - ☐ **Daily**
   - ☐ **Several times a week**
   - ☐ **Several times a month**

Employee Signature: _____

(Signature) (Date)

FM Safety & Health Office Approved:_____

(Signature) (Date)

Personal Protective Equipment FRS 1-189000 Work Order Number WT-100-____ (Shop Suffix)

Safety Boots, if approved, will be issued no more than once every two years. Safety boots will be replaced within the two-year period if damaged or significantly worn or if the employee can no longer achieve a good fit. Submit this form for all safety boot requests and boot replacement approval.