(Establishment Name)_____

(Establishment Number)_____

Pre-Operational SSOP Report

Month_____ , 200 _____

Day	Equipment Name	Pass	Fail	Checked by (initials)	Comments	Corrective Actions

Verified by _____Date _____

Establishment Name_____

Establishment Number_____

Operational SSOP Report

Date_____

	Pass	Fail	Checked by (Initials)	Time of check	Comments	Corrective Actions
Personal Hygiene						
Product Handling						
Insect & Rodent Control						
Mid-Shift Cleaning						

Verified by _____Date _____