Arkansas Department of Labor
OSHA CONSULTATION
REQUEST FORM
Fax to (501) 682-4532

LEGAL NAME OF COMPANY _____

NAME OF CONTACT PERSON: _____

CONTACT PERSON TITLE _____ ***PHONE:*** _____ ***EXT#:*** _____

STREET ADDRESS OF COMPANY: _____

MAILING ADDRESS: _____

CITY, STATE ZIP: _____

TYPE OF BUSINESS: _____

SIC CODE: _____

NUMBER OF EMPLOYEES AT THIS LOCATION: _____

NUMBER OF EMPLOYEES IN CORPORATION (In United States): _____

OTHER RELEVANT INFORMATION: _____

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