OSHA's Form 300A (Rev. 01/2004)

Summary of Work-Related Injuries and Illnesses

Year 20__ __

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

All establishments covered by Part 1904 must complete this Summary page, even if no work-related injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate before completing this summary.

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the Log. If you had no cases, write "0."

Employees, former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR Part 1904.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
_____	2	_____	1
(G)	(H)	(I)	(J)

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
44	_____
(K)	(L)

Injury and Illness Types

Total number of . . .	(M)		
(1) Injuries	3	(4) Poisonings	_____
		(5) Hearing loss	_____
(2) Skin disorders	_____	(6) All other illnesses	_____
(3) Respiratory conditions	_____		

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

Establishment information

Your establishment name SKi Solutions

Street _____

City _____ State AK ZIP _____

Industry description (*e.g., Manufacture of motor truck trailers*)

_____

Standard Industrial Classification (SIC), if known (*e.g., 3715*)

__ __ __ __

OR

North American Industrial Classification (NAICS), if known (e.g., 336212)

__ __ __ __ __ __

Employment information

(If you don't have these figures, see the Worksheet on the back of this page to estimate.)

Annual average number of employees _____

Total hours worked by all employees last year _____

Sign here

Knowingly falsifying this document may result in a fine.

I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.

_____ _____
Company executive Title

( ) - / /
Phone Date

OSHA's Form 301
Injury and Illness Incident Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____

Title _____

Phone (_____)_____-_____ Date ____/____/____

Information about the employee

1) Full name Robert Lane, Janitor

2) Street _____

City _____ State _____ ZIP _____

3) Date of birth 5/20/1983

4) Date hired 10/28/2010

5) ☑ Male
☐ Female

Number of days away from work = 40

Information about the physician or other health care professional

6) Name of physician or other health care professional _____

7) If treatment was given away from the worksite, where was it given?

Facility _____

Street _____

City _____ State _____ ZIP _____

8) Was employee treated in an emergency room?
☑ Yes
☐ No

9) Was employee hospitalized overnight as an in-patient?
☐ Yes
☑ No

Information about the case

10) Case number from the *Log* 1 *(Transfer the case number from the Log after you record the case.)*

11) Date of injury or illness 3/1/2017

12) Time employee began work 9:00 (AM) / PM

13) Time of event 3:15 AM / (PM) ☐ Check if time cannot be determined

14) ***What was the employee doing just before the incident occurred?*** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

Worker was climbing a ladder while carrying cleaning supplies.

15) ***What happened?*** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

Employee lost grip on the ladder and fell to the floor.

16) ***What was the injury or illness?*** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

Fractured right hip.

17) ***What object or substance directly harmed the employee?*** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*

The ground.

18) ***If the employee died, when did death occur?*** Date of death ____/____/____

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If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____

Title _____

Phone (_____)_____-_____ Date ____/____/____

Information about the employee

1) Full name Chris Moore, Maintenance

2) Street _____

City _____ State _____ ZIP _____

3) Date of birth 6/11/1977

4) Date hired 9/15/2005

5) ☑ Male
☐ Female

Number of days away from work = 4

Information about the physician or other health care professional

6) Name of physician or other health care professional _____

7) If treatment was given away from the worksite, where was it given?

Facility _____

Street _____

City _____ State _____ ZIP _____

8) Was employee treated in an emergency room?
☑ Yes
☐ No

9) Was employee hospitalized overnight as an in-patient?
☐ Yes
☑ No

Information about the case

10) Case number from the *Log* 2 *(Transfer the case number from the Log after you record the case.)*

11) Date of injury or illness 7/10/2012

12) Time employee began work 9:00 (AM) / PM

13) Time of event 2:00 AM / (PM) ☐ Check if time cannot be determined

14) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

Repairing a lawn mower

15) **What happened?** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

Worker's finger became caught in the mower's engine.

16) **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

Laceration to the left hand.

17) **What object or substance directly harmed the employee?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*

18) **If the employee died, when did death occur?** Date of death ____/____/____