OSHA'S Form 300 (Rev. 01/2004) Log of Work-Related Injuries and Illnesses

You must record information about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness incident report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

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.

City

Establishment name



State

Form approved OMB no. 1218-0176

All other illnesses

(6)

Hearing Loss

(5)

0

Hearing Loss

(5)

0

All other illnesses

Classify the case Identify the person Describe the case Enter the number of (A) (B) (C) (D) (E) (F) CHECK ONLY ONE box for each case based on davs the injured or ill Check the "injury" column or choose one type of Case Employee's Name Job Title (e.g., Date of Where the event occurred (e.g. Describe injury or illness, parts of body affected, the most serious outcome for that case: worker was: illness: Loading dock north end) and object/substance that directly injured or made No. Welder) injury or person ill (e.g. Second degree burns on right onset of (M) illness forearm from acetylene torch) On job Days away Away transfer or Skin Disorde Death Remained at work (mo./day) Respiratory Condition from work Poisoning From restriction Work (days) Job transfer or Other record-Injury (days) Irestriction able cases (2) (3) (4) (G) (H) (I) (J) (K) (L) (1)

Page totals

Be sure to transfer these totals to the Summary page (Form 300A) before you post it.

0

0

0

0

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave. NW. Washington, DC 20210, Do not send the completed forms to this office.

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0

0

0

Injury

(1)

0

Skin Disorder

(2)

0

Respiratory Condition

(3)

0

Poisoning

(4)

OSHA's Form 300A (Rev. 01/2004) Summary of Work-Related Injuries and Illnesses

Year_____ 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 injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete

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 1904.35, in OSHA's Recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases			
Total number of deaths 0 (G)	Total number of cases with days away from work 0 (H)	Total number of cases with job transfer or restriction 0 (I)	Total number of other recordable cases 0 (J)
Number of Days			
Total number of days away from work		Total number of days of job transfer or restriction	
<u>0</u> (К)	_	0 (L)	-
Injury and Illness 1	Гурез		
Total number of (M)			
(1) Injury	0	(4) Poisoning	0

 (2) Skin Disorder
 0
 (5) Hearing Loss

 (3) Respiratory
 0
 (6) All Other Illnesses

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

0

Public reporting burden for this collection of information is estimated to average 58 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.

Estab	blishment information		
Y	Your establishment name		
S	Street		
С	City State	e	Zip
Ir	ndustry description (e.g., Manufacture of motor truck t	trailers)	
S	Standard Industrial Classification (SIC), if known (e.g.,	SIC 3715)	
NR N	North American Industrial Classification (NAICS), if kn	own (e.g., 336212)	
mplo	oyment information		
A	Annual average number of employees		
	Fotal hours worked by all employees last /ear		
ign l	here		
к	Knowingly falsifying this document may result in a	a fine.	
l Ci	certify that I have examined this document and that t complete.	o the best of my knowledge the entries are true, a	ccurate, and
	Company executive		Title
_	Phone		Date

OSHA's Form 301 Injuries and Illnesses 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	Labo
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Occupational Safety and Health Administration

Form approved	OMB no.	1218-017
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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.

Date _

Completed by

Title

Phone

		· · · · · · · · · · · · · · · · · · ·
	Information about the employee	Information about the case
	1) Full Name	10) Case number from the Log(Transfer the case number from the Log after you record the case.)
e of the ble work-	2) Street	11) Date of injury or illness
ther with ses and	CityStateZip	12) Time employee began work AM/PM
elp the e extent	3) Date of birth	13) Time of event AM/PM Check if time cannot be determined
		*Please do not include any personally identifiable information (PII) pertaining to worker(s) involved in the incident (e.g., no names, phone numbers, or SSNs) in the following fields.
e njury or irm or an ition, ble	 4) Date hired 5) Male Female 	*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."
at form, on asked CFR t keep ar to	Information about the physician or other health care professional 6) Name of physician or other health care professional	*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."
m, you ed.	7) If treatment was given away from the worksite, where was it given? Facility Street	affected. Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
	CityStateZip 8) Was employee treated in an emergency room? Yes No	 *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.
	9) Was employee hospitalized overnight as an in-patient?	18) If the employee died, when did death occur? Date of death

Public reporting burden for this collection of information is estimated to average 22 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Persons are not required to respond to the collection of information unless it displays a current valid OMB control number. If you have any comments about this estimate or any other aspects of this data collection, including suggestions for reducing this burden, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.