Oklahoma Department of Labor
Statistical Research Unit
4001 North Lincoln Boulevard
Oklahoma City, OK 73105-5212

Year 2007

OFFICIAL STATE BUSINESS

Public Sector Guidelines of Occupational Injuries and Illnesses

Recordkeeping Year 2007

FORMS ONLY

THIS REPORT IS MANDATORY

OK Form 300 -- Log of Work-Related Injuries & Illnesses

Oklahoma Department of Labor
405-528-1500; 888-269-5353; www.labor.ok.gov

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.

Year 2007

You must record information about every work-related death and about every work-related injury or illness that involves loss of conciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries that are diagnosed by a physician or licensed health care professional (PHLCP). You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12. Feel free to use two (2) single lines for a single case if you need to. You must complete an IInjury & Illness Incident Report (OK Form 301) for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call the Oklahoma Department of Labor for help at 1-888-269-5353, Ext. 251

Establishment

Location

Physical City

Identify the person		***Describe the case***				***Classify the case***													
						Using these four categories, "X" ONLY the most serious result for each case:				***Enter number of days injured or ill worker was:***		***"X" injury column or choose one illness type:***							
(A) **Case no.**	(B) **Employee's name**	(C) **Job title** *(e. g., Welder)*	(D) **Date of injury or onset of illness**	(E) **Event location** *(e.g., Loading dock, north end)*	(F) **Describe injury or illness, parts of body affected, and object/ substance that directly injured or made person ill** *(e.g., Second degree burns on right forearm from acetylene torch)*	***Death***	***Days away from work***	***Remained at work***				(M)							
								On job transfer or restriction	Other recordable cases	Away from work	On job transfer or restriction	Injury	Skin disorder	Respiratory condition	Poisoning	Hearing loss	All other illnesses		
						(G)	(H)	(I)	(J)	(K)	(L)	(1)	(2)	(3)	(4)	(5)	(6)		
										days	days								
										days	days								
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					Page totals ➤														

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

Injury | Skin disorder | Respiratory condition | Poisoning | Hearing loss | All other illnesses

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. If you have any comments about these estimates or any other aspects of this data collection, contact: Oklahoma Department of Labor, 4001 North Lincoln Boulevard, Oklahoma City, OK 73105; 1-888-269-5353, Ext. 251.

Page ___ of ___

(1) (2) (3) (4) (5) (6)

OK Form 300A -- Summary of Work-Related Injuries & Illnesses

Oklahoma Department of Labor
405-528-1500; 888-269-5353; www.labor.ok.gov

Mandatory **Year 2007**

Section 1: Establishment Information

Establishment _____ ID _____

Location _____ Physical Address _____

Mailing Address _____ Physical City _____

Mailing City _____ Mailing State _____ Mailing Zip _____ Telephone _____

Instructions: All establishments covered by Part 1904 must complete the questions below, 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 total 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 OK Form 300 in its entirety. They also have limited access to the OK Form 301 or its equivalents. See 29 CFR Part 1904.35, in OSHA's recordkeeping rules, for further details on the access provisions of these forms.

1. Annual average number of employees: → _____ 2. Total hours worked by all employees last year: → _____

3. Check any conditions that might have affected your answers to questions 1 and 2 above during 2007:

- ☐ Strike or lockout
- ☐ Natural disaster or adverse weather conditions
- ☐ Other reason: _____
- ☐ Shutdown or layoff
- ☐ Shorter work schedules or fewer pay periods than usual
- ☐ Nothing unusual happened to affect our employment or hours figures.
- ☐ Seasonal work
- ☐ Longer work schedules or more pay periods than usual

4. Did you have ANY occupational injuries or illnesses during 2007?

☐ Yes. Go to Section 2: OK Form 300A -- Summary of Work-Related Injuries and Illnesses, 2007. ☐ No. Go to Section 3: Contact Information and Certification.

Section 2: OK Form 300A -- Summary of Work-Related Injuries and Illnesses, 2007

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
_____ (G)	_____ (H)	_____ (I)	_____ (J)

For each case in Column G or H complete the OK Form 301 -- Injury & Illness Report -- Case Information

Number of Days

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

Injury and Illness Types

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

The total **Number of Cases** recorded in G + H + I + J must equal total **Injury & Illnesses Types** recorded in M (1 + 2 + 3 + 4 + 5 + 6).

Section 3: Contact Information and Certification (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.

Name of Agency Executive / Representative _____ Telephone _____ Ext. _____ Fax Number _____

Title _____ E-Mail _____ Today's Date (MM/DD/YYYY) _____

Public reporting burden for this collection of information is estimated to average 50 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. If you have any comments about these estimates or any other aspects of this data collection, contact: Oklahoma Department of Labor, 4001 North Lincoln Boulevard, Oklahoma City, OK 73105; 1-888-269-5353, Ext. 251

Post this Summary page from February 1st to April 30th, 2008.

OK Form 301 -- Injury & Illness Report -- Case Information **Year 2007**

Oklahoma Department of Labor
405-528-1500; 888-269-5353; www.labor.ok.gov

Case Information

_____
ID

Go to your completed OK Form 300. Copy the case information from that form into the spaces below. ***When submitting for the public sector survey, only include the OK Form 301 - Case Information page for incidents resulting in Cases with Days Away From Work (column H) or Death (column G).***

Case number from Log (column A)	**Employee's name** (column B)	**Job title** (column C)	**Date of Injury or onset of Illness** (column D)	**Number of days away from work** (column K)	**Number of days of job transfer or restriction** (column L)

Tell us about the Employee

1. **Check the category which best describes the employee's regular type of job or work:** (optional)

- ☐ Office, professional, business, or management staff
- ☐ Sales
- ☐ Product assembly, product manufacture
- ☐ Repair, installation or service of machines, equipment
- ☐ Construction
- ☐ Other: _____
- ☐ Healthcare
- ☐ Delivery or driving
- ☐ Food service
- ☐ Cleaning, Maintenance of building, grounds
- ☐ Material handling (e.g. stocking, loading/ unloading, moving, etc.)
- ☐ Farming

2. **Employee's race or ethnic background:** (optional-check one or more)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Not available

3. **Employee's age:** _____ ***OR*** **date of birth:** _____
MM-DD-YYYY

4. **Employee's date hired:** _____
MM-DD-YYYY

OR **check length of service at establishment when incident occurred:**

- ☐ Less than 3 months
- ☐ From 3 to 11 months
- ☐ From 1 to 5 years
- ☐ More than 5 years

5. **Employee's sex:**

- ☐ Male
- ☐ Female

Tell us about the Incident

6. **Time employee began work:** _____ ☐ *am* ☐ *pm*

7. **Time of event:** _____ ☐ *am* ☐ *pm* *OR* ☐ *Check if time cannot be determined*

Event occurred: ☐ *before* ☐ *during* ☐ *after* work shift

8. **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."

9. **What happened?** Tell us how the injury or illness 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."

10. **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."

11. **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.

12. **Was the employee treated in an emergency room?** ☐ *yes* ☐ *no*

13. **Was employee hospitalized overnight as an in-patient?** ☐ *yes* ☐ *no*

14. **If the employee died, record date of death:** _____
MM-DD-YYYY

N	P	S	E	SS	OCC