### OSHA's Form 300 Log of Work-Related Injuries and Illnesses

**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

(1) (2) (3)

(4)

blishment name		
	State	

You must record information about every work-related death and 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 Part 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.

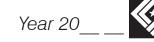
Establishment name
City

Page \_\_\_\_ of \_\_\_\_

Ident	ify the person		Describe tl	he case		Class	ify the ca	ase								
(A) Case	(B) Employee's name	(C) Job title	(D) Date of injury	(E) Where the event occurred	57 1 7 7		Using these four categories, check ONLY the most serious result for each case:			Enter the ne days the inj ill worker w	umber of jured or vas:	Check choos				
no.		(e.g., Welder)	or onset of illness	(e.g., Loading dock north end)			Days away from work (H)		d at work Other record- able cases (J)	On job transfer or restriction (K)	Away from work (L)	(M) (1)	(C) Skin disorder	(c) Respiratory condition	guinosiod (4)	( <b>1</b> ) All other ( <b>1</b> ) All other
			/ month/day			(G)					days					
			month/day							days	days					
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			month/day							days	days					
				er response, including time to review information. Persons are not require		ese totals to		y page (Form 30		ost it.		Injury	n disorder	espiratory condition	Poisoning	All other illnesses

the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not requi 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 other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

### OSHA's Form 300A Summary of Work-Related Injuries and Illnesses



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 record keeping rule, for further details on the access provisions for these forms.

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)	(L)
Number of D			
Total number of da job transfer or rest		otal number of days vay from work	
(K)	_	(L)	
Injury and II	ness Types		
Total number of (M)			
) Injuries		(4) Poisonings	
Skin disorders		(5) All other illnesse	es
) Respiratory condit	ions		

Your establishment name	
Street	
City	State ZIP
Industry description (e.g., Ma	unufacture of motor truck trailers)
Standard Industrial Classifica	ation (SIC), if known ( <i>e.g., SIC 3715</i> )
Employment informa Worksheet on the back of this pag	ation (If you don't have these figures, see the new these of the stimate.)
Annual average number of en	mployees
Total hours worked by all em	ployees last year
Sign here	
Knowingly falsifying th	nis document may result in a fine.
	ned this document and that to the best of my true, accurate, and complete.
Company executive	Title
() -	/ / Date

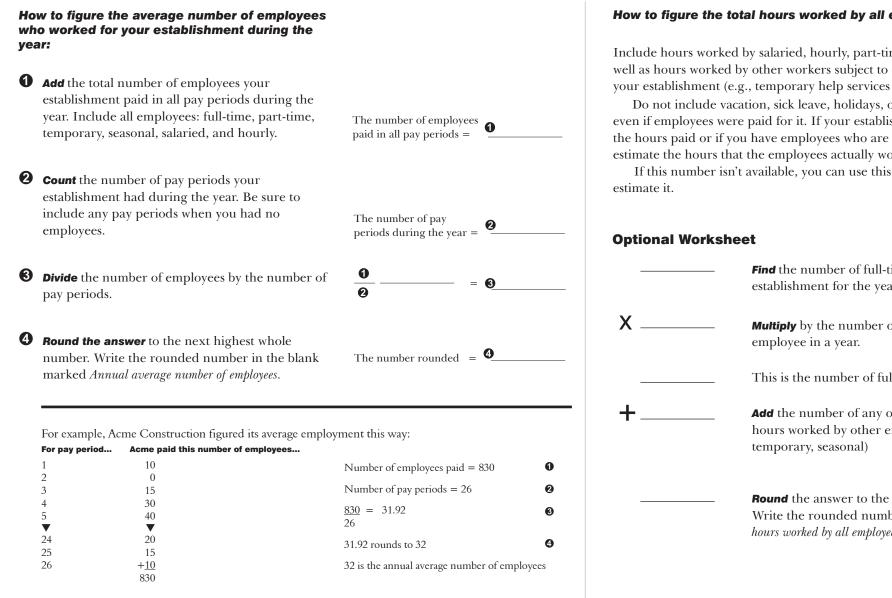
#### Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

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. 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 other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

### **Optional**

## Worksheet to Help You Fill Out the Summary

At the end of the year, OSHA requires you to enter the average number of employees and the total hours worked by your employees on the summary. If you don't have these figures, you can use the information on this page to estimate the numbers you will need to enter on the Summary page at the end of the year.



#### How to figure the total hours worked by all employees:

Include hours worked by salaried, hourly, part-time and seasonal workers, as well as hours worked by other workers subject to day to day supervision by your establishment (e.g., temporary help services workers).

Do not include vacation, sick leave, holidays, or any other non-work time, even if employees were paid for it. If your establishment keeps records of only the hours paid or if you have employees who are not paid by the hour, please estimate the hours that the employees actually worked.

If this number isn't available, you can use this optional worksheet to

Find the number of full-time employees in your establishment for the year.

*Multiply* by the number of work hours for a full-time

This is the number of full-time hours worked.

Add the number of any overtime hours as well as the hours worked by other employees (part-time,

**Round** the answer to the next highest whole number. Write the rounded number in the blank marked Total hours worked by all employees last year.

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# OSHA's Form 301 Injury and Illness Incident Report

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		Inform
1) Full name	10)	Case num
	11)	Date of in
2) Street	12)	Time emp
City State ZIP	. 13)	Time of e
<ul> <li>3) Date of birth / /</li> <li>4) Date hired /</li> <li>5)  Male</li> <li>Female</li> </ul>	14)	<b>What wa</b> tools, eq carrying
Information about the physician or other health care professional       6) Name of physician or other health care professional		<b>What ha</b> fell 20 fe develope
7) If treatment was given away from the worksite, where was it given?     Facility     Street		<b>What wa</b> more sp tunnel s
City State ZIP 8) Was employee treated in an emergency room? 9) Was employee hospitalized overnight as an in-patient? 9 Var		What ob "radial a
□ Yes □ No	18)	If the en

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Form approved OMB no. 1218-0176

#### Information about the case

10) Case number from the Log	(Transfer the case number from the Log after you record the case.)
11) Date of injury or illness//	_
12) Time employee began work	_ AM / PM
13) Time of event	AM / PM Check if time cannot be determined
tools, equipment, or material the employee	<b>he incident occurred?</b> Describe the activity, as well as the was using. Be specific. <i>Examples:</i> "climbing a ladder while or ine from hand sprayer"; "daily computer key-entry."
	urred. <i>Examples:</i> "When ladder slipped on wet floor, worker orine when gasket broke during replacement"; "Worker
	part of the body that was affected and how it was affected; be " <i>Examples:</i> "strained back"; "chemical burn, hand"; "carpal
17) What object or substance directly harmed t "radial arm saw." If this question does not ap	the employee? Examples: "concrete floor"; "chlorine"; ply to the incident, leave it blank.
18) If the employee died, when did death occu	1? 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 Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.