



Summary of Work-Related Injuries and Illnesses

N.J. Department of Labor & Workforce Development
Public Employees Occupational Safety and Health

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 and accurate before completing the 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".

Employers, former employees and their representatives have the right to review the NJOSH Form 300 in its entirety. They also have limited access to the NJOSH 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
_____	_____	_____	_____
(G)	(H)	(I)	(J)

Number of Days

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

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. Comments regarding this form should be sent to the Office of Public Employees Occupational Safety and Health, NJ Department of Labor and Workforce Development, PO Box 386, Trenton, NJ 08625.

Public Employer

Department or Agency _____

Street _____

City _____ State _____ ZIP _____

Industry description (e.g. Police, DPW, Sewerage Treatment, School) _____

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

OR

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

Employment Information

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.

Public Employer Management Representative _____ Title _____

() _____

Phone _____ Date _____