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

## 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

Establishment name

Form approved OMB no. 1218-0176

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.

rm. If y	ou're not sure whether a case	e is recordable, call your i	local OSHA office for	or help.	, ,					City			Sta	ate		
ldent	ify the person		Describe t	he case			sify the ca									
(A) (B) Case Employee's name		(C) Job title	(D)  Date of injury		(F) Describe injury or illness, parts of body affected,	CHECK ONLY ONE box for each case based on the most serious outcome for that case:				Enter the number of days the injured or ill worker was:		Check the "Injury" column choose one type of illness:			ımn o ess:	
no.		(e.g., Welder)	or onset of illness	(e.g., Loading dock north end)	and object/substance that directly injured or made person ill (e.g., Second degree burns on			Remaine	ed at Work	Away	On job	(M)	order	yıc n	g loss	
					right forearm from acetylene torch)	Death	Days away from work		Other record- able cases	Away from work	transfer or restriction	Injury	Skin dise	Respirat	Poisonin Hearing	All other
						(G)	(H)	(I)	(J)	(K)	(L)				(4) (5)	) (6
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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. 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 Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

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

| Injury | Skin disorder | Condition | Con

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

# 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 recordkeeping rule, for further details on the access provisions for these forms.

Number of C	ases		
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)	(1)	(J)
Number of D	)ays		
Total number of da from work		otal number of days of job ansfer or restriction	
(K)	_	(L)	
Injury and II	Iness Types		
Total number of (M)			
) Injuries		(4) Poisonings	
		(5) Hearing loss	
) Skin disorders		(6) All other illness	es
Respiratory condit	ions		

#### 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 58 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 Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Street  City St  Industry description (e.g., Manufacture of motor tru  Standard Industrial Classification (SIC), if know  OR  North American Industrial Classification (NAIC  —		
Industry description (e.g., Manufacture of motor trues and and Industrial Classification (SIC), if known on the control of the		
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North American Industrial Classification (NAIC ————————————————————————————————————		15)
Employment information (If you don't 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 materials.		
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Company executive		Title
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## 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.



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	/	/

Street					
City		State		ZIP	
Date of birth/	/				
Date hired/_	/				
☐ Male ☐ Female					
- Female					
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Information all professional Name of physician or	other health care professi				
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<b>professional</b> Name of physician or		onal			
professional  Name of physician or  If treatment was given	other health care professi	onal where wa	ıs it giv	en?	
professional  Name of physician or  If treatment was given  Facility	other health care professi away from the worksite, v	onal	s it giv	en?	
professional  Name of physician or  If treatment was given  Facility	other health care professi	onal	s it giv	en?	
professional  Name of physician or  If treatment was given  Facility  Street	other health care professi away from the worksite, v	onal	as it giv	en?	
professional  Name of physician or  If treatment was given  Facility  Street  City  Was employee treated	other health care professi away from the worksite, v	onal	as it giv	en?	
professional  Name of physician or  If treatment was given  Facility  Street	away from the worksite, v	onal	as it giv	en?	

	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
14)	tools, equipment, or material the employee v	the incident occurred? Describe the activity, as well as the was using. Be specific. Examples: "climbing a ladder while rine from hand sprayer"; "daily computer key-entry."
15)		urred. Examples: "When ladder slipped on wet floor, worker rine when gasket broke during replacement"; "Worker
16)		part of the body that was affected and how it was affected; be Examples: "strained back"; "chemical burn, hand"; "carpal
17)	What object or substance directly harmed "radial arm saw." If this question does not app	the employee? Examples: "concrete floor"; "chlorine"; oly to the incident, leave it blank.
18)	If the employee died, when did death occu	7? Date of death//