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.

Year 20__ __

U.S. Department of Labor
Occupational Safety and Health Administration

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.

Establishment name _____

City _____ *State* _____

Identify the person			Describe the case			Classify the case: 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 or choose one type of illness:					
								Remained at Work									
(A) Case no.	(B) Employee's name	(C) Job title (*e.g., Welder*)	(D) Date of injury or onset of illness	(E) Where the event occurred (*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 (G)	Days away from work (H)	Job transfer or restriction (I)	Other record-able cases (J)	Away from work (K)	On job transfer or restriction (L)	(M) Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)
____	_____	_____	___/___ month/day	_____	_____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	_____	_____	___/___ month/day	_____	_____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	_____	_____	___/___ month/day	_____	_____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	_____	_____	___/___ month/day	_____	_____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	_____	_____	___/___ month/day	_____	_____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	_____	_____	___/___ month/day	_____	_____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	_____	_____	___/___ month/day	_____	_____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	_____	_____	___/___ month/day	_____	_____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	_____	_____	___/___ month/day	_____	_____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	_____	_____	___/___ month/day	_____	_____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	_____	_____	___/___ month/day	_____	_____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	_____	_____	___/___ month/day	_____	_____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
					Page totals ➤	____	____	____	____	____	____	____ Injury (1)	____ Skin disorder (2)	____ Respiratory condition (3)	____ Poisoning (4)	____ Hearing loss (5)	____ All other illnesses (6)

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

Page ___ **of** ___

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.

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

Summary of Work-Related Injuries and Illnesses

Year 20__ __

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

Injury and Illness Types

Total number of . . . (M)

(1) Injuries _____

(2) Skin disorders _____

(3) Respiratory conditions _____

(4) Poisonings _____

(5) Hearing loss _____

(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 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.

Establishment information

Your establishment name _____

Street _____

City _____ State _____ ZIP _____

Industry description (*e.g., Manufacture of motor truck trailers*)

_____

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

___ ___ ___ ___

OR

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

___ ___ ___ ___ ___ ___

Employment information

(If you don't have these figures, see the 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 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.

_____
Company executive — Title

( ) - / /
Phone — Date