OSHA's Form 300 (Rev. 04/2004)

Log of Work-Related Injuries and Illnesses

Note: You can type input into this form and save it. Because the forms in this recordkeeping package are "fillable/writable" PDF documents, you can type into the input form fields and then save your inputs using the free Adobe PDF Reader. In addition, the forms are programmed to auto-calculate as appropriate.

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

Please 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.*
- *Significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional.*
- *Work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12.*

Reminders:

- *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.*
- *Feel free to use two lines for a single case if you need to.*
- *Complete the 5 steps for each case.*

Establishment name ______________________

City ______________________ State __________

Step 1. Identify the person			Step 2. Describe the case			Step 3. Classify the case — SELECT ONLY ONE circle based on the most serious outcome:				Step 4. Enter the number of days the injured or ill worker was:		Step 5. Select one column: (M)					
								Remained at Work					Illness				
(A) Case no.	(B) Employee's name	(C) Job title (e.g., Welder)	(D) Date of injury or onset of illness (e.g., 2/10)	(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)	(G) Death	(H) Days away from work	(I) Job transfer or restriction	(J) Other record-able cases	(K) Away from work	(L) On job transfer or restriction	(1) Injury	(2) Skin disorder	(3) Respiratory condition	(4) Poisoning	(5) Hearing loss	(6) All other illnesses
Reset ____	____	____	____ / ____ month / day	____	____	○	○	○	○	____ days	____ days	○	○	○	○	○	○
Reset ____	____	____	____ / ____ month / day	____	____	○	○	○	○	____ days	____ days	○	○	○	○	○	○
Reset ____	____	____	____ / ____ month / day	____	____	○	○	○	○	____ days	____ days	○	○	○	○	○	○
Reset ____	____	____	____ / ____ month / day	____	____	○	○	○	○	____ days	____ days	○	○	○	○	○	○
Reset ____	____	____	____ / ____ month / day	____	____	○	○	○	○	____ days	____ days	○	○	○	○	○	○
Reset ____	____	____	____ / ____ month / day	____	____	○	○	○	○	____ days	____ days	○	○	○	○	○	○
Reset ____	____	____	____ / ____ month / day	____	____	○	○	○	○	____ days	____ days	○	○	○	○	○	○
Reset ____	____	____	____ / ____ month / day	____	____	○	○	○	○	____ days	____ days	○	○	○	○	○	○
Reset ____	____	____	____ / ____ month / day	____	____	○	○	○	○	____ days	____ days	○	○	○	○	○	○
Reset ____	____	____	____ / ____ month / day	____	____	○	○	○	○	____ days	____ days	○	○	○	○	○	○
					Page totals ▶	0	0	0	0	0	0	0	0	0	0	0	0
												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.

Add a Form Page

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 301 (Rev. 04/2004)

Injury and Illness Incident Report

Note: You can type input into this form and save it. Because the forms in this recordkeeping package are "fillable/writable" PDF documents, you can type into the input form fields and then save your inputs using the free Adobe PDF Reader. In addition, the forms are programmed to auto-calculate as appropriate.

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

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 the printout or insert additional form pages in the PDF, and then use as many as you need.

Completed by ____________________

Title ____________________

Phone __________ **Date** __________
Month Day Year

Information about the employee

1) **Full name** ____________________

2) **Street** ____________________

City __________ **State** ______ **ZIP** ______

3) **Date of birth** __________
Month Day Year

4) **Date hired** __________
Month Day Year

5) ○ **Male** ○ **Female**

Information about the physician or other health care professional

6) **Name of physician or other health care professional**

____

7) **If treatment was given away from the worksite, where was it given?**

Facility ____________________

Street ____________________

City __________ **State** ______ `**ZIP** ______

8) **Was employee treated in an emergency room?**
○ **Yes**
○ **No**

9) **Was employee hospitalized overnight as an in-patient?**
○ **Yes**
○ **No**

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** __________
Month Day Year

12) **Time employee began work** (HH:MM) __________ ○ **AM** ○ **PM**

13) **Time of event** (HH:MM) __________ ○ **AM** ○ **PM** ○ **Check if time cannot be determined**

*** Re fields 14 to 17:** Please do not include any personally identifiable information (PII) pertaining to worker(s) involved in the incident (e.g., no names, phone numbers, or Social Security numbers).

14)* ***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."

15)* ***What Happened?*** **Tell us how the injury 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."

16)* ***What was the injury or illness?*** Tell us the part of the body that was affected and how it was affected. *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

*17)** ***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.*

18) ***If the employee died, when did death occur?*** **Date of death** __________
Month Day Year

Add a Form Page

Reset

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