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.

City

Establishment name

Year	
U.S. Department	of Labor
Occupational Safety and Hea	alth Administration

State ____

You must record information 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 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.

Form approved OMB no. 1218-0176

Identify the person Describe the case				Classify the case													
(A) Case	(B) Employee's Name	Job Title (e.g., Da	(D) Date of	Date of Where the event occurred (e.g. Loading dock north end) onset of illness	(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)	CHECK ONLY ONE box for each case based on the most serious outcome for that case:				Enter the nu days the inju worker was	Check the "injury" column or choose one type of illness:						
No.		Welder)	injury or onset of illness (mo./day)								(M)						
						Death	Days away from work	Remain	ed at work	Away On job transfer o restriction		(141)	sorder	atory on	in in	g Loss	All other illnesses
								Job transfer or restriction	Other recordable cases	Work (days)	(days)	Injury	Skin Disorde	Respiratory Condition	Poisoning	Hearing Loss	All oth
						(G)	(H)	(I)	(J)	(K)	(L)	(1)	(2)	(3)	(4)	(5)	(6)
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					Page totals	0	0	0	0	0	0	0	0	0	0	0	0
					Be sure to transfer these totals	to the	Summary	page (Form	300A) before	e you post	it.	Injury	sorder	Respiratory Condition	Poisoning	g Loss	esses
to review Persons a number.	the instruction, search and gather are not required to respond to the c If you have any comments about the	the data needed, and collection of information of each or any	d complete and on unless it dis y aspects of thi	14 minutes per response, including time review the collection of information. plays a currently valid OMB control s data collection, contact: US Ave, NW, Washington, DC 20210. Do									Skin Disorder	Resp Cor	Poi	Hearing Loss	All other illnesses
	the completed forms to this office.	ucs, 1100111 11-3044, 21	oo consulullon	i Ave, ivvv, vvasiililyluli, DC 20210. DO					Page	1 of 1		(1)	(2)	(3)	(4)	(5)	(6)