

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" 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.



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 **Mike Brown**
 Title **Warehouse Supervisor**
 Phone **555 . 555 . 5555** Date **2 25 2015**
 Month Day Year

Information about the employee

1) Full name **William Smith**
 2) Street **555 Local Street**
 City **Anytown** State **WA** ZIP **98229**

3) Date of birth **3 14 1968**
 Month Day Year
 4) Date hired **9 1 2005**
 Month Day Year
 5) Male Female

Information about the physician or other health care professional

6) Name of physician or other health care professional
Dr. John Jones

7) If treatment was given away from the workplace, where was it given?
 Facility **Family Medical Associates**
 Street **333 Business Street**
 City **Anytown** State **WA** ZIP **98229**

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 **2** (Transfer the case number from the Log after you record the case.)
 11) Date of injury or illness **2 24 2015**
 Month Day Year
 12) Time employee began work **7** AM PM
 13) Time of event AM PM Check if time cannot be determined

* Be 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."
Unloading a delivery of supplies that had arrived overnight. The materials were needed for a project with a tight deadline and needed to be offloaded quickly.

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."
Employee was in a hurry to unload the truck since production told him they needed the supplies right away. He did not follow proper lifting procedures.

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"; "compartment syndrome."
Employee's back became sore at home that night. The next morning he went to his doctor, who said his back was strained and he needed to take a few days off to recover.

17) What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "metal 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

Save Input

Add a Form Page

Reset

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.

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: **CSU Widget Factory**
 City: **Orange Beach** State: **AL**
 Year **20 15**
 U.S. Department of Labor
 Occupational Safety and Health Administration
 Form approved OMB no. 1213-0116

Identify the person

Describe the case

Classify the case

Enter the number of days the injured or ill worker was:

Select the "injury" column or choose one type of 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, injured or made person ill (e.g., Second degree burns on right forearm from acetylene torch)	(G) Death	(H) Days away from work or restriction	(I) Job transfer or restriction	(J) Other recordable cases	(K) Days away from work	(L) On job transfer or restriction	(M) Injury	(N) Skin disorder	(O) Respiratory condition	(P) Poisoning	(Q) Hearing loss	(R) All other illnesses
1	Jane Doe	Welder	1 / 18	Welding Area	Burned Retinas - both eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 days	2 days	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2	William Smith	Warehouse Worker	2 / 24	Storeroom	Lumbar Strain	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	4 days	4 days	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3	Nellie Kershaw	Production Line Worker	5 / 18	Main Production Floor	Respiratory Condition	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	14 days	14 days	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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OSHA's Form 300A (Rev. 01/2004)

Summary 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/printable" PDF documents, you can type into the input form fields and then save your inputs using the free Adobe PDF Reader.

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
0	3	0	0

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
8	14

Injury and Illness Types

Total number of . . .	(1) Injuries	(2) Skin disorders	(3) Respiratory conditions	(4) Poisonings	(5) Hearing loss	(6) All other illnesses
(M)	2	0	1	0	0	0

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 30 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 CSU Widget Factory
Street 21982 University Lane
City Orange Beach State AL Zip 36561
Industry description (e.g., *Manufacture of motor truck trailers*)
Widget Manufacturing
Standard Industrial Classification (SIC), if known (e.g., 3715)
OR
North American Industrial Classification (NAICS), if known (e.g., 336212)
326199

Employment Information (If you don't have these figures, see the Worksheet on the next page to estimate.)
Annual average number of employees 27
Total hours worked by all employees last year 58675

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 ____/____/____