OSHA Form 300

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 ____________

Department of Consumer & Business Services
Oregon Occupational Safety & Health Division (OR-OSHA)

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, job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related 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 OAR 437-001-0700. Use more lines for each case if needed. You must complete an Injury and Illness Incident Report (DCBS form 801) 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 OR-OSHA office for help.

Establishment name: ____________________

City: ____________________ State: ____________

Identify the person			Describe the case			Classify the case											
						Using these 4 categories, enter "1" in only the most serious result for each case:*				**Enter the number of days the injured / worker was:**		**Enter "1" in the "injury" column or choose one type of illness:*** (M)					
(A) Case no.	(B) Employee's name	(C) Job title *(e.g., "welder")*	(D) Date of injury or illness	(E) Where the event occurred *(e.g., "loading dock - north end")*	(F) Describe Injury/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)	Remained at work: Job transfer or restriction (I)	Remained at work: Other record-able cases (J)	Away from work (K)	On job transfer or restriction (L)	Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing Loss (5)	All other illnesses (6)
						0	0	0	0	days	days	0	0	0	0	0	0
						0	0	0	0	days	days	0	0	0	0	0	0
						0	0	0	0	days	days	0	0	0	0	0	0
						0	0	0	0	days	days	0	0	0	0	0	0
						0	0	0	0	days	days	0	0	0	0	0	0
						0	0	0	0	days	days	0	0	0	0	0	0
						0	0	0	0	days	days	0	0	0	0	0	0
						0	0	0	0	days	days	0	0	0	0	0	0
						0	0	0	0	days	days	0	0	0	0	0	0
						0	0	0	0	days	days	0	0	0	0	0	0
						0	0	0	0	days	days	0	0	0	0	0	0
						0	0	0	0	days	days	0	0	0	0	0	0
						0	0	0	0	days	days	0	0	0	0	0	0
					Page Totals	0	0	0	0	0 days	0 days	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 (OSHA Form 300A) before you post it

*** Using "1" instead of an "x" allows the columns to total automatically.**

Page ____ of ____

OSHA Form 300A
Summary of Work-Related Injuries and Illnesses

Year 20

Department of Consumer & Business Services
Oregon Occupational Safety &
Health Division (OR-OSHA)

Form approved OMB no. 1218-0176

All establishments covered by OAR 437-001-0700 must complete this Summary, 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, write the totals below, make sure you've added the entries from every page of the *Log*. If you haven't had any 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 *DCBS Form 801* or its equivalent. See OAR 437-001-0700(20)

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	_____	(4) Poisonings	_____
(2) Skin disorders	_____	(5) Hearing Loss	_____
(3) Respiratory conditions	_____	(6) All other illnesses	_____

Keep this Summary posted from February 1 to April 30 of the year following the year covered by this form.

Establishment Information

Your establishment name _____

Street _____

City _____ State _____ ZIP _____

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

_____

Standard 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: ____/ ___/ ____