

# 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: \_\_\_\_\_

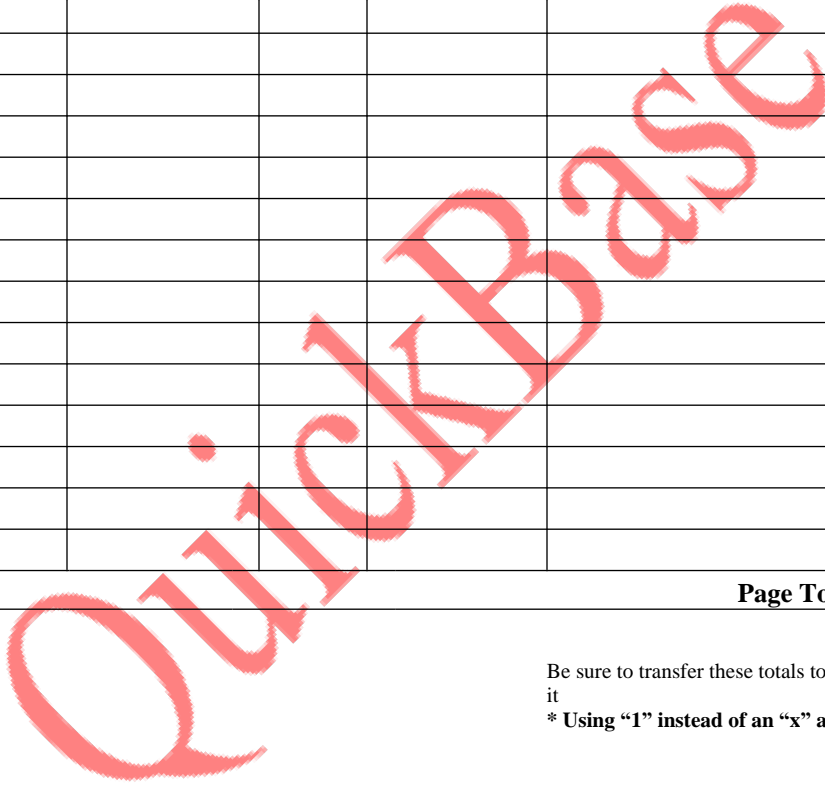
City: \_\_\_\_\_ State: \_\_\_\_\_

Identify the person		Describe the case		Classify the case				Enter the number of days the injured / worker was:		Enter "1" in the "injury" column or choose one type of illness:*							
(A) Case no.	(B) Employee's name	(C) Job title <i>(e.g., "welder")</i>	(D) Date of injury or illness	(E) Where the event occurred <i>(e.g., "loading dock - north end")</i>	(F) Describe Injury/Illness, parts of body affected, and object/substance that directly injured or made person ill <i>(e.g., "second degree burns on right forearm from acetylene torch")</i>	Using these 4 categories, enter "1" in only the most serious result for each case:*						Enter "1" in the "injury" column or choose one type of illness:*					
						Death	Days away from work	Remained at work									
								Job transfer or restriction	Other recordable cases	Away from work	On job transfer or restriction	Injury	Skin disorder	Respiratory condition	Poisoning	Hearing Loss	All other illnesses
						(G)	(H)	(I)	(J)	(K)	(L)	(1)	(2)	(3)	(4)	(5)	(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
<b>Page Totals</b>						0	0	0	0	0 days	0 days	0	0	0	0	0	0

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 \_\_\_\_\_

Injury	Skin disorder	Respiratory condition	Poisoning	Hearing Loss	All other illnesses
(1)	(2)	(3)	(4)	(5)	(6)



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

### 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

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