OSHA Form 300 — Log of Work-Related Injuries and Illnesses

Year 20___ Establishment name: _____ City: _____ State: ____ Free template by Safety Team Technologies — safetyteamtech.com

Case No.	Employee Name	Job Title	Date of injury (mo/day)	Where event occurred	Describe injury/illness, body part, object/substance	(G) Death	(H) Days away	(I) Transfer/ restrict	(J) Other	(K) Days away #	(L) Transfer days #	Type 1-6
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												

Classify each case in ONE of columns G–J (most serious outcome). Columns M type: 1 Injury · 2 Skin disorder · 3 Respiratory · 4 Poisoning · 5 Hearing loss · 6 All other illness.

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

Post February 1 – April 30 of the year following the year covered. Even if no injuries occurred, you must post the summary with zeros.

Number of Cases		Number of Days	
Total deaths (G)		Total days away from work (K)	
Cases w/ days away (H)		Total days transfer/restriction (L)	
Cases w/ transfer/restriction (I)			
Other recordable cases (J)			
Injury & Illness Types			
(1) Injuries		(4) Poisonings	
(2) Skin disorders		(5) Hearing loss	
(3) Respiratory conditions		(6) All other illnesses	

Establishment Information

Establishment name	
Street / City / State / ZIP	
Industry / NAICS code	
Annual average # of employees	
Total hours worked last year	
Company executive name & title	
Signature & date	

OSHA Form 301 — Injury and Illness Incident Report

Complete within 7 calendar days of learning that a recordable injury or illness occurred.

About the Employee

Full name	
Street address / City / State / ZIP	
Date of birth	
Date hired	
Sex (M/F)	

About the Case

Case number (from 300 Log)	
Date of injury/illness	
Time began work / Time of event	
What was the employee doing before the incident?	
What happened?	
What was the injury or illness?	
What object or substance harmed the employee?	
Date of death (if applicable)	

Physician / Treatment

Name of physician or health care professional	
Facility name & address	
Treated in emergency room? (Y/N)	
Hospitalized overnight as in-patient? (Y/N)	

Completed By

Name & title	
Phone	
Date completed	