

Summary of Work-Related Injuries and Illnesses

Year 20 _____



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

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 58 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 _____
 Street _____
 City _____ State _____ ZIP _____
 Industry description (e.g., *Manufacture of motor truck trailers*) _____
 Standard Industrial Classification (SIC), if known (e.g., 3715) _____
 OR _____
 North American 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 _____