

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.

Form approved OMB no. 1218-0176

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 _____
 City _____ State _____

Identify the person			Describe the case			Classify the case				Enter the number of days the injured or ill worker was:		Check 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 onset of illness	(E) Where the event occurred <i>(e.g., Loading dock north end)</i>	(F) Describe injury or 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>	CHECK ONLY ONE box for each case based on the most serious outcome for that case:				Away from work	On job transfer or restriction	(M)					
						Death	Days away from work	Job transfer or restriction	Other recordable cases	(K)	(L)	Injury	Skin disorder	Respiratory condition	Poisoning	Hearing loss	All other illnesses
						(G)	(H)	(I)	(J)	_____ days	_____ days	(1)	(2)	(3)	(4)	(5)	(6)
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_____	_____	_____	_____/_____/_____ month/day	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ days	_____ days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____/_____/														