Cal/OSHA Form 300 (Rev. 7/2007) Appendix A

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.
See CCR Title 8 14300.29(b)(6)-(10)

Year 20__

CAL OSHA

Department of Industrial Relations
Division of Occupational Safety and Health

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 CCR Title 8 Section 14300.8 through 14300.12. Feel free to use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (Cal/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 Cal/OSHA office for help.

Establishment name ______________

City ______________ State ______________

Identify the person			Describe the case			Classify the case											
						Using these four categories, check ONLY the most serious result for each case:				**Enter the number of days the injured or ill worker was:**		**Check the "Injury" column or choose one type of illness:** (M)					
						Death	Days away from work	Remained at work									
(A) Case no.	(B) Employee's name	(C) Job title (e.g., *Welder*)	(D) Date of injury or onset of illness (**e.g. month/day**)	(E) Where the event occurred (*e.g., Loading dock north end*)	(F) Describe injury or 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*)	(G)	(H)	(I) Job transfer or restriction	(J) Other record-able cases	(K) Away from work	(L) On job transfer or restriction	(1) Injury	(2) Skin disorder	(3) Respiratory condition	(4) Poisoning	(5) Hearing loss	(6) All other illnesses
___	___	___	month/day	___	___	☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
___	___	___	month/day	___	___	☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
___	___	___	month/day	___	___	☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
___	___	___	month/day	___	___	☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
___	___	___	month/day	___	___	☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
___	___	___	month/day	___	___	☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
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___	___	___	month/day	___	___	☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
___	___	___	month/day	___	___	☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
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___	___	___	month/day	___	___	☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
___	___	___	month/day	___	___	☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
					Page totals ➤	___	___	___	___	___	___	___ (1) Injury	___ (2) Skin disorder	___ (3) Respiratory condition	___ (4) Poisoning	___ (5) Hearing loss	___ (6) All other illnesses

Be sure to transfer these totals to the Summary page (Form 300A) before you post it.

Cal/OSHA Form 300A (Rev. 7/2007) **Appendix B**

Annual Summary of Work-Related Injuries and Illnesses

Year

Department of Industrial Relations
Division of Occupational Safety & Health

All establishments covered by CCR Title 8 Section 14300 must complete this Annual 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. 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 Cal/OSHA Form 300 in its entirety. They also have limited access to the Cal/OSHA Form 301 or its equivalent. See CCR Title 8 Section 14300.35, in Cal/OSHA's recofdkeeping 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 . . . (M)			
(1) Injuries	_____	(4) Poisonings	_____
		(5) Hearing loss	_____
(2) Skin disorders	_____	(6) All other Illnesses	_____
(3) Respiratory conditions	_____		

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

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., SIC 3715*)

____ ____ ____ ____

Employment information

(If you don't have these figures, use the optional Worksheet 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

Cal/OSHA Form 301
Injury and Illness Incident Report

Appendix C

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.
See CCR Title 8 14300.29(b)(6)-(10)

Department of Industrial Relations
Division of Occupational Safety & Health

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with *Log of Work-Related Injuries and Illnesses* and the accompanying *Annual Summary*, these forms help the employer and Cal/OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the instructions and information asked for on this form.

According to CCR Title 8 Section 14300.33 Cal/OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____

Title _____

Phone (_____)_____-_____ **Date** ____/____/____

Information about the employee

1) **Full name** _____

2) **Street** _____

City _____ **State** _____ **ZIP** _____

3) **Date of birth** ____/____/____

4) **Date hired** ____/____/____

5) ☐ Male
☐ Female

Information about the physician or other health care professional

6) **Name of physician or other health care professional** _____

_____

7) **If treatment was given away from the worksite, where was it given?**

Facility _____

Street _____

City _____ **State** _____ **ZIP** _____

8) **Was employee treated in an emergency room?**
☐ Yes
☐ No

9) **Was employee hospitalized overnight as an in-patient?**
☐ Yes
☐ No

Information about the case

10) **Case number from the *Log*** _____ *(Transfer the case number from the Log after you record the case.)*

11) **Date of injury or illness** ____/____/____

12) **Time employee began work** _____ AM / PM

13) **Time of event** _____ AM / PM ☐ Check if time cannot be determined

14) *What was the employee doing just before the incident occurred?* **Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific.** ***Examples:*** **"climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."**

15) *What happened?* **Tell us how the injury occurred.** ***Examples:*** **"When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."**

16) *What was the injury or illness?* **Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore."** ***Examples:*** **"strained back"; "chemical burn, hand"; "carpal tunnel syndrome."**

17) *What object or substance directly harmed the employee?* ***Examples:*** **"concrete floor"; "chlorine"; "radial arm saw."** ***If this question does not apply to the incident, leave it blank.***

18) *If the employee died, when did death occur?* **Date of death** ____/____/____

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.
23. Other Workers Injured or Ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

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. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)
Signature & Title
Date (mm/dd/yy)

DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

Please do not use this column
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

Complete This Side First

Cal/OSHA Reporting Tool: Non-Hospital Programs

Instructions – Use this page to determine if Cal/OSHA needs to be notified of a workplace incident. If **ANY** "Yes" box is checked below, notifications have to occur within 8-hours of a triggering incident. The form on the back of this tool can be used to gather the information needed for reporting. During normal business hours (M-F 8 AM – 5 PM), OSH Section Staff can make the notification to Cal/OSHA for you. You must speak directly with someone at the OSH Section for this to happen. Do **not** just leave a message! At other times or if you cannot reach someone at OSH, the Supervisor or Manager should call Cal/OSHA at 415-972-8670 to make the report. Ask to speak with the Duty Officer.

Death (8 CCR 342(a))	**YES**	**NO**
D1. Did an employee die at their place of employment? **Note: Cause of death does not matter. All fatalities must be reported.**		
Serious Injury or Illness (8 CCR 342(a)) If an employee is transported from work to a hospital via ambulance and admitted, the incident must be reported to Cal/OSHA within 8 hours of the employee being admitted to the hospital. The reason for the admission (industrial injury, personal illness) does not matter. If an employee is transported, the Supervisor or Manager must follow up to see if the employee was admitted. If this information cannot be obtained, the incident must be reported to Cal/OSHA.	**YES**	**NO**
S1. Was an employee hospitalized as an inpatient for other than medical observation for a period in excess of 24 hours because of an injury or illness either (a) occurring in their workplace or (b) in connection with their employment?		
S2. Did an employee lose any member of the body because of an injury or illness either (a) occurring in their workplace or (b) in connection with their employment?		
S3. Did an employee suffer a serious degree of physical disfigurement because of an injury or illness either (a) occurring in their workplace or (b) in connection with their employment?		

Complete This Side ONLY If "Yes" Answer Given on the First Page

Information Required for Reportable Incidents

Instructions – If a "yes" answer is given to any of the questions on the opposite side of this form, complete as much of this form as possible and contact the OSH Section at 554-2787. **Do NOT** delay contacting the OSH Section if all of the listed information is not immediately available; supplemental reports can be filed but a strict reporting timetable must be met.

Company / Employer:	
Name	**CCSF Dept of Public Health**
Mailing Address	
Telephone Number	
Person Reporting Incident:	
Name	
Job Title	
Telephone Number	
Date & Time of Incident	
Incident Location:	
Address:	
Name of Contact Person	
Telephone # of Contact	
Injured Employee(s):	
Name	
Job Title	
Employee's Union	
Home Address	
Nature or Description of Injury	
Where Was the Injured Employee Taken?	
Names of Law Enforcement Agencies Responding to Incident (If Any)	
Summary Description of Incident	
Has the Incident Scene or Equipment Involved Been Altered?	_____ **No** _____ **Yes, Explain:**

Note – Secure incident scene until further instructions are received. Do NOT alter scene or move equipment unless it presents a severe safety or health hazard to leave it untouched.