NJOSH 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.

Public Employer:

Page

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Year:	=	LASON AND WORKFORCE DEVISIONMENT
	N.J. Department	

Workforce Development

11177

Public Employees Occupational Safety & Health

You must record information 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 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 the Office of Public Employees Occupational Safety and Health for help.

					ou're not sure whether a case is recordable, call the Office of F			State:									
mployee	es Occupational Safety and Health	n for help.						County:				Other:					
I	dentify the person			Describe the	case	Classi	ify the case)									
(A) (B) Case Employee's Name No.		(C) Job Title (e.g., Welder)	(C) (D) (E) (F) b Title (e.g., Welder) injury or Loading dock north end) Describe injury or illness, parts of boom and object/substance that directly injury.	(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	CHECK ONLY ONE box for each case based on the most serious outcome for that case:				Enter the nu days the inju worker was:	ured or ill	Check the		eck the "injury" column or choose one type of illness:				
			onset of illness (mo./day)		forearm from acetylene torch)	Death	Death Days away from work Remained at work		Away Con job transfer or restriction		sorder	atory on	ng	g Loss	All other illnesses		
								Job transfer or restriction	Other recordable cases	Work (days)	(days)	Injury	Skin Disord	Respiratory Condition	Poisoning	Hearing Loss	All oth
						(G)	(H)	(1)	(J)	(K)	(L)	(1)	(2)	(3)	(4)	(5)	(6)
														<u> </u>			
														<u> </u>			
														<u> </u>			
													-	<u> </u>			
					Page totals	0	0	0	0	0	0	0	0	0	0	0	0
					Be sure to transfer these totals	to the	Summary r	page (Form	300A) before	e vou post	it.	<u>Sir</u>	Jer	yrc on	gu	SS	es

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Questions regarding this form should be directed to the Office of Public Employees Occupational Safety and Health, New Jersey Department of Labor and Workforce Development, PO Box 386, Trenton, New Jersey 08625. Do not send the completed forms to this office.

NJOSH - 300A

Summary of Work-Related Injuries and Illnesses

Year N.J. DOL & WD

Public Employees Occupational Safety & Health

All establishments covered by Part 1904 must complete this Summary page, even if no 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."

Employers, former employees and their representatives have the right to review the NJOSH Form 300 in its entirety. They also have limited access to the NJOSH Form 301 or its equivalent. See 29 CFR 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				
0	0	0	0				
(G)	(H)	(1)	(J)				
Number of Days							
Total number of days away from work		Total number of days of job transfer or restriction					
0 (K)		0 (L)					
Injury and Illness Ty	/pes						
Total number of (M)							
(1) Injury	0	(4) Poisoning	0				
(2) Skin Disorder	0	(5) Hearing Loss	0				
(3) Respiratory Condition	0	(6) All Other Illnesses	0				

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 50 minutes per response, including time to review the instruction, 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. Comments regarding this form should be sent to the Office of Public Employees Occupational Safety and Health, NJ Department of Labor and Workforce Development, PO Box 386, Trenton, NJ 08625.

ublic Employer		
Department or Agency		
Street		
City	State	Zip
Industry description (e.g., Polic	e, DPW, Sewerage Treatment, School)	
	sification (NAICS), if known (e.g., 336212)	
mployment information	<u> </u>	
Annual average number of em	oloyees	
Total hours worked by all empl year	oyees last	
gn here		
Knowingly falsifying this doc	ument may result in a fine.	
I certify that I have examined this	document and that to the best of my knowledge the e	entries are true, accurate, and complete.
Public Employer Manageme	nt Representative	Title
Phone		Date

NJOSH Form 301 Injuries and Illnesses Incident Report

Information about the employee

8) Was employee treated in an emergency room?

9) Was employee hospitalized overnight as an in-patient?

Yes

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.

Information about the case

*16) What was the injury or illness? Tell us the part of the body that was affected and how it was affected. 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



Public Employees Occupational Safety & Health

This Injury and Illness Incident Report is one of the first forms you must fill out when a recordable workrelated injury or illness has occurred. Together with the Log of Work-Related Injuries and Illnesses and the accompanying Summary, these forms help the employer and PEOSH 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 information asked for on this form.

According to Public Law 91-596 and 29 CFR 1904, 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.

Comple	ted by		
Title			
Phone		Date	

1)	Full Name	10)	Case number from the Log	((Transfer the o	case number from the Log after you record the case.)
2)	Street	11)	Date of injury or illness			
	CityStateZip	12)	Time employee began work		AM/PM	
3)	Date of birth	13)	Time of event		AM/PM	Check if time cannot be determined
			se do not include any personally identifiable ers, or SSNs) in the following fields.	e information	n (PII) pertaining	g to worker(s) involved in the incident (e.g., no names, ph
4)	Date hired	*14)				ident occurred? Describe the activity, as v
5)	Male					as using. Be specific. Examples: "climbing alorine from hand sprayer"; "daily computer le
,	Female		entry."			
	Information about the physician or other health care professional					
6)	Name of physician or other health care professional	*15)		as sprayed	with chlori	xamples: "When ladder slipped on wet floor ne when gasket broke during replacement";
7\	If treatment was given away from the worksite, where was it given?					
()	i ii ii eaiiiieiii was giveii away iioiii iile Wolksile, Wilele was il giveii?					

Public reporting burden for this collection of information is estimated to average 22 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Persons are not required to respond to the collection of information unless it displays a current valid OMB control number. If you have any comments about this estimate or any other aspects of this data collection, including suggestions for reducing this burden, contact: The Office of Public Employees Occupational Safety and Health, NJ Department of Labor & Workforce Development, PO Box 386, Trenton, New Jersey 08625.

State Zip _____