



2

## **Learning Objectives**

MEMIC Safety Academy

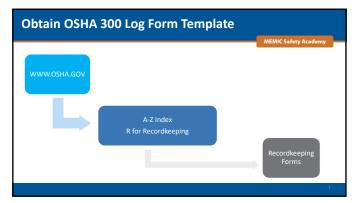
- $\bullet$  Examine the content and details of the OSHA 300 log.
- Determine what information is required to be entered into each column of the OSHA 300 log using real life examples.
- $\bullet$  Identify common errors employers make when completing their OSHA 300 log.

3

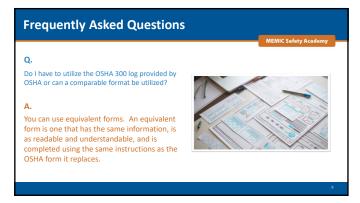


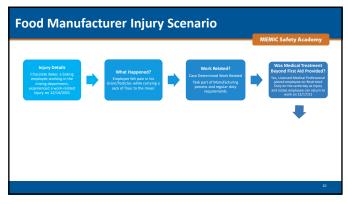


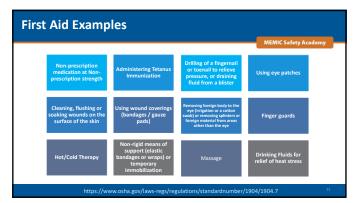


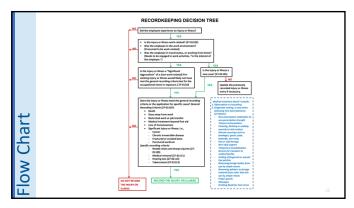


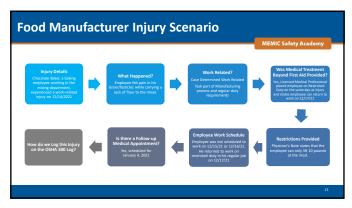






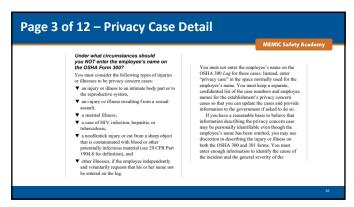




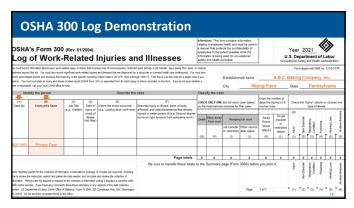


| 0                                                     | SHA 3                                                                                              | 00                                                                       | Lo                                               | g Demo                                                                                                                                                                  | onstration                                                                                                                                                                                                                            |                                      |                                                |                                                  |                                              |                                |                                                   |            |                 |                          |           |              |                    |
|-------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|------------------------------------------------|--------------------------------------------------|----------------------------------------------|--------------------------------|---------------------------------------------------|------------|-----------------|--------------------------|-----------|--------------|--------------------|
|                                                       | 's Form 300<br>of Work                                                                             |                                                                          |                                                  | Injuries ar                                                                                                                                                             | nd IIInesses                                                                                                                                                                                                                          | relatin<br>a man<br>employ<br>inform | g to employe<br>ner that prot<br>yees to the e | cts the confic<br>ident possible<br>used for occ | ust be used in<br>lentiality of<br>while the |                                | U                                                 | Year       | par             | men                      | t of L    | abor         | ion                |
| eatment beyond<br>scord work-relati<br>eed to. You mu | first aid. You must also record<br>injuries and linesses that it<br>st complete an injury and line | d significant work or<br>sett any of the spec<br>ss incident report (C   | risted injuries<br>(fic recording                | and illnesses that are diagnosed by<br>orteria listed in 29 CFR 1904.8 thro                                                                                             | of work activity or job transfer, days away from work,<br>a physician or licensed health care professional. You<br>ugh 1904.12. Feel fee to use two lines for a single ca<br>y or liness recorded on this form. If you're not sure wh | must also<br>se if you               |                                                | Establishn                                       |                                              |                                | A.B.C.                                            | Bakin      | ıg Cı           | ompa                     | ıny, I    |              |                    |
|                                                       | e, call your local OSHA office                                                                     | for help.                                                                |                                                  |                                                                                                                                                                         |                                                                                                                                                                                                                                       |                                      |                                                | City                                             | Mix                                          | ing Pla                        | ce                                                | State      | _               | Per                      | nsyl      | vania        | 1                  |
| (A)<br>Case No.                                       | (B)<br>Employee's Name                                                                             | (C)<br>Job Title<br>(e.g., Welder)                                       | (D)<br>Date of<br>injury or                      | (E) Where the event occurred (e.s. Loading dock north end)                                                                                                              | (F)<br>Describe injury or illness, parts of body                                                                                                                                                                                      | CHEC                                 |                                                | box for each<br>soutcome for                     |                                              | Enter the days the i           | njured or ill                                     |            | k the "i        | njury" o<br>type o       |           | or choos     | e one              |
|                                                       |                                                                                                    |                                                                          | onset of<br>liness<br>(mo./day)                  |                                                                                                                                                                         | injured or made person if (e.g. Second degree<br>burns on right forearm from acetylene torch)                                                                                                                                         | Death                                | from work                                      |                                                  |                                              | Away<br>From<br>Work<br>(days) | On job<br>transfer<br>or<br>restriction<br>(days) | (A) Arriva | Skin Disorder   | Respiratory<br>Condition | Poisoning | Hearing Loss | Al other linesses  |
|                                                       |                                                                                                    |                                                                          |                                                  |                                                                                                                                                                         |                                                                                                                                                                                                                                       | (Q)                                  | (M)                                            | 0                                                | (J)                                          | (K)                            | (L)                                               | (1)        | (2)             | (3)                      | (4)       | (5)          | (6)                |
| 021-1001                                              |                                                                                                    |                                                                          |                                                  |                                                                                                                                                                         |                                                                                                                                                                                                                                       | +                                    |                                                |                                                  |                                              |                                |                                                   |            | $\vdash$        | Н                        |           |              | Н                  |
|                                                       |                                                                                                    |                                                                          |                                                  |                                                                                                                                                                         | Page totals                                                                                                                                                                                                                           | 0                                    | 0                                              | 0                                                | 0                                            | 0                              | 0                                                 | 0          | 0               | 0                        | 0         | 0            | 0                  |
| me to review the<br>domation. Pers<br>A/B control num | instruction, search and gather<br>ons are not required to respon-<br>ber. If you have any comme    | r the data needed, a<br>d to the collection of<br>this about these esti- | end complete<br>l'information :<br>mattes or any | 4 minutes per response, including<br>and review the collection of<br>uniform the collection of<br>aspects of this data collection,<br>Constitution Ave. NW. Washinston. | Be sure to transfer these totals                                                                                                                                                                                                      | to the                               | Summary                                        | page (Form                                       | 300A) before                                 | you pos                        |                                                   | (a)        | S Sain Disorder | Respiratory              | Poisoning | Hearing Loss | A Al other Bresses |

|                                                                                                   |                |                                                                   | MEN                                | ЛIC Saf                          | ety Acad       |
|---------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------|------------------------------------|----------------------------------|----------------|
| Q.                                                                                                |                | st complete an injury and sin-<br>le, call your local OSHA office |                                    | John Form J                      | VII) or eq     |
| Are there situations where I do not put the                                                       | lden           | tify the person                                                   | -                                  |                                  |                |
| employee's name on the forms for privacy reasons?                                                 | (A)<br>sse No. | (B)<br>Employee's Name                                            | (C)<br>Job Title<br>(e.g., Welder) |                                  | Where (e.g. Li |
| A.                                                                                                |                |                                                                   |                                    | onset of<br>iliness<br>(mo./day) |                |
| res, if you have a "privacy concern case," you may not enter the employee's name on the OSHA 300  |                |                                                                   |                                    | ,                                |                |
| g. Instead, enter "privacy case" in the space<br>ormally used for the employee's name. You        | 21-1001        | Privacy Case                                                      | Baker                              | 12/14/21                         | Mix            |
| nust keep a separate, confidential list of the case<br>umbers and employee names for your privacy |                |                                                                   |                                    |                                  |                |
| concern cases so you can update the cases.                                                        |                | unden for this collection of info                                 |                                    |                                  |                |







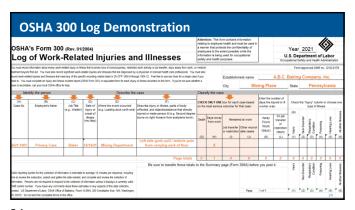
| 0                                                                         | SHA 3                                                                                                | 00                                                                                             | Lo                                            | g Demo                                                                      | onstration                                                                                                                                                                                                                                  |                                        |                                                 |                                                  |                                             |                                          |                                                   |       |                   |                              |                      |              |                        |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------|--------------------------------------------------|---------------------------------------------|------------------------------------------|---------------------------------------------------|-------|-------------------|------------------------------|----------------------|--------------|------------------------|
|                                                                           | 's Form 300<br>of Work-                                                                              |                                                                                                |                                               | Injuries ar                                                                 | nd Illnesses                                                                                                                                                                                                                                | relating<br>a many<br>employ<br>inform | g to employe<br>ner that profe<br>yees to the e | cts the confid<br>dent possible<br>used for occi | ust be used in<br>entiality of<br>while the |                                          | U                                                 | Year  | part              | men                          |                      |              |                        |
| eatment beyond<br>ecord work-relat<br>eed to. You mu                      | d first aid. You must also recorded injuries and linesses that m                                     | d significant work-neet any of the spec<br>se incident report (C                               | sisted injuries<br>(fic recording             | and illnesses that are diagnosed by<br>orteria listed in 29 CFR 1904.8 thro | d work activity or job transfer, days away from work, or<br>a physician or licensed health care professional. You i<br>ugh 1904.12. Feel fee to use two lines for a single cas<br>y or liness recorded on this form. If you're not sure whe | rust also<br>if you                    |                                                 | Establishm                                       |                                             | ing Pla                                  | A.B.C.                                            |       |                   | ompa                         | ny, I                | nc.          |                        |
|                                                                           | .,,                                                                                                  | or reg.                                                                                        |                                               | Describe the                                                                |                                                                                                                                                                                                                                             |                                        | ify the cas                                     |                                                  | INIX                                        | ang Pia                                  | ce                                                | State |                   | rei                          |                      | ivani        | _                      |
| (A)<br>Case No.                                                           | (8)<br>Employee's Name                                                                               | (C)<br>Job Title<br>(e.g., Welder)                                                             | (D)<br>Date of<br>injury or<br>onset of       | (E) Where the event occurred (e.g. Loading dock north end)                  | (F)<br>Describe injury or liness, parts of body                                                                                                                                                                                             | CHECK                                  | K ONLY ONE                                      | box for each<br>soutcome for                     |                                             | Enter the ri<br>days the is<br>worker wi | njuned or ill                                     | Check |                   |                              | olumn o<br>f iliness | or choos     | se one                 |
|                                                                           |                                                                                                      |                                                                                                | ilness<br>(mo./day)                           |                                                                             | burns on right forearm from acetylene torch)                                                                                                                                                                                                | Death                                  | Days away<br>from work                          |                                                  | Other record-                               | Away<br>From<br>Work<br>(days)           | On job<br>transfer<br>or<br>restriction<br>(days) | tes.  | ain Disorder      | tespiratory<br>ondition      | Disoning             | earing Loss  | 4 other Bresse         |
|                                                                           |                                                                                                      |                                                                                                |                                               |                                                                             |                                                                                                                                                                                                                                             | (G)                                    | (80)                                            | 0                                                | (1)                                         | (80)                                     | (L)                                               | m     | (2)               | (3)                          | (4)                  | (5)          | (6)                    |
| 2021-1001                                                                 | Privacy Case                                                                                         | Baker                                                                                          |                                               |                                                                             |                                                                                                                                                                                                                                             |                                        |                                                 |                                                  |                                             |                                          |                                                   |       |                   |                              |                      |              | F                      |
|                                                                           |                                                                                                      |                                                                                                |                                               |                                                                             | Page totals                                                                                                                                                                                                                                 | 0                                      | 0                                               |                                                  | 0                                           | 0                                        | 0                                                 | 0     | 0                 | 0                            | 0                    | 0            | 0                      |
| me to review the<br>elormation. Pen<br>SMB control num<br>contact. US Dep | e instruction, search and gather<br>sons are not required to respon<br>riber. If you have any commer | r the data needed, a<br>d to the collection of<br>nts about these esti-<br>of Statistics, Room | end complete<br>Information s<br>mates or any | niess it displays a currently valid                                         | Be sure to transfer these totals                                                                                                                                                                                                            | to the                                 | Summary                                         | page (Form                                       |                                             | you posi                                 |                                                   | (1)   | (S) Skin Disorder | (3) Respiratory<br>Condition | (4)                  | Hearing Loss | (i) All other thresses |

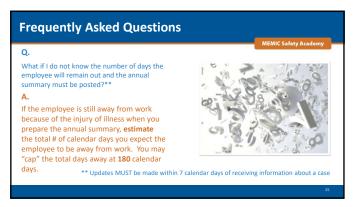
| OSHA'                                                         | s Form 30                                                                                     | 0 (Rev. 01/                                                             | 2004)                                                  |                                                                                                                                               | onstration                                                                                                                                                                                                                                                                         | relatin<br>a man<br>emplo<br>inform | g to employe<br>ner that proti<br>yees to the e<br>lation is being | cts the confi<br>ident possible<br>used for occ | nust be used in<br>dentiality of<br>while the |                                        | U                                                 | Year              |                  |                          | <b>≪</b>          | ⇒<br>abor           |                   |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------|----------------------------------------|---------------------------------------------------|-------------------|------------------|--------------------------|-------------------|---------------------|-------------------|
| fou must record in<br>realtment beyond t<br>ecord work-relate | formation about every work<br>first aid. You must also reco<br>d injuries and linesses that o | related injury or illn<br>rd significant work-n<br>neet any of the spec | ess that involved<br>elated injuries<br>also recording | ves loss of consciousness, restricts<br>and illnesses that are diagnosed by<br>criteria listed in 29 CFR 1904.8 tiro                          | d work activity or job transfer, days away from work, or a physician or licensed health care professional. You ugh 100x 12. Feel fee to use two lines for a single or any or liness recorded on this form. If you're not severed on this form. If you're not severed on this form. | r medical<br>must also<br>e if you  |                                                                    | Establishr                                      | nent name                                     |                                        | A.B.C.                                            | pational :<br>For | lafety<br>m appr | and He<br>roved (        | ath Adr<br>MB no. | ninistrat<br>1218-0 |                   |
| ase is recordable                                             | , call your local CSHA office                                                                 | for help.                                                               |                                                        |                                                                                                                                               |                                                                                                                                                                                                                                                                                    |                                     |                                                                    | City                                            | Mix                                           | ing Pla                                | ce                                                | State             | $\Box$           | Per                      | ınsyl             | vania               |                   |
| Ident                                                         | ify the person                                                                                |                                                                         |                                                        | Describe the                                                                                                                                  | case                                                                                                                                                                                                                                                                               | Class                               | sify the cas                                                       | 0                                               |                                               |                                        |                                                   |                   |                  |                          |                   |                     |                   |
| (A)<br>Case No.                                               | (8)<br>Employee's Name                                                                        | (C)<br>Job Title<br>(e.g., Welder)                                      | (D)<br>Date of<br>injury or<br>onset of                | (E)<br>Where the event occurred<br>(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.e. Second decree                                                                                                                                          | on the                              |                                                                    | box for each<br>outcome for                     |                                               | Enter the r<br>days the ir<br>worker w | njured or ill                                     | Check             |                  |                          | olumn o           | r choos             | rone              |
|                                                               |                                                                                               |                                                                         | iness<br>(mo./day)                                     |                                                                                                                                               | arguned or made person is (e.g. become degree<br>burns on right forearm from acety/ene torch)                                                                                                                                                                                      | Death                               | Days away<br>from work                                             |                                                 | Other recordable cases                        | Away<br>From<br>Work<br>(days)         | On job<br>transfer<br>or<br>restriction<br>(days) | , Lugary          | Skin Disorder    | Respiratory<br>Condition | Poisoning         | Hearing Loss        | All other Bresse  |
| $\rightarrow$                                                 |                                                                                               |                                                                         |                                                        |                                                                                                                                               |                                                                                                                                                                                                                                                                                    | (3)                                 | (8)                                                                | 0                                               | (J)                                           | (K)                                    | (L)                                               | (1)               | (2)              | (3)                      | (4)               | (5)                 | (6                |
| 2021-1001                                                     | Privacy Case                                                                                  | Baker                                                                   | 12/14/21                                               |                                                                                                                                               |                                                                                                                                                                                                                                                                                    |                                     |                                                                    |                                                 |                                               |                                        |                                                   |                   | L                |                          |                   |                     | L                 |
|                                                               |                                                                                               |                                                                         |                                                        |                                                                                                                                               |                                                                                                                                                                                                                                                                                    |                                     |                                                                    |                                                 |                                               |                                        |                                                   |                   |                  |                          |                   |                     | L                 |
|                                                               |                                                                                               |                                                                         |                                                        |                                                                                                                                               | Page totals                                                                                                                                                                                                                                                                        | 0                                   | 0                                                                  | 0                                               |                                               | 0                                      | 0                                                 | 0                 | 0                | 0                        | 0                 | 0                   | . 0               |
| me to review the<br>eformation. Perso                         | instruction, search and gathers<br>are not required to respon                                 | or the data needed, and to the collection o                             | end complete<br>l'information i                        | 4 minutes per response, including<br>and review the collection of<br>unless it displays a currently valid<br>assects of this data collection. | Be sure to transfer these totals                                                                                                                                                                                                                                                   | to the                              | Summary                                                            | page (Form                                      | 300A) before                                  | you post                               | t it.                                             | Injury            | Skin Disorder    | Respiratory<br>Condition | Poisoning         | Hearing Loss        | All other Bresses |
| contact: US Depa                                              |                                                                                               | of Statistics, Floors                                                   |                                                        | Constitution Ave., NIII, Washington,                                                                                                          |                                                                                                                                                                                                                                                                                    |                                     |                                                                    |                                                 | Page                                          | 1 of 1                                 |                                                   | (1)               | (2)              | (3)                      | (4)               | (5)                 | (6                |

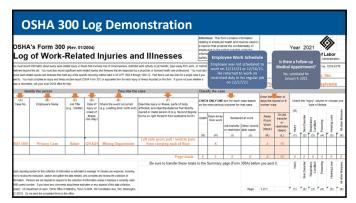
| Log                                                | 's Form 300<br>of Work-                                             |                                                                       |                                         | Injuries ar                                                                  | nd Illnesses                                                                                                                                                                                                                              | relating<br>a mann<br>employ<br>inform | to employe<br>ner that prote<br>rees to the e | rm contains in<br>a health and m<br>cts the confid<br>dent possible<br>used for occurroses. | ust be used in<br>entiality of<br>while the |                                          |                                         | Year         | part          | men         |                      |              |     |
|----------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------------------|---------------------------------------------|------------------------------------------|-----------------------------------------|--------------|---------------|-------------|----------------------|--------------|-----|
| atment beyond<br>cord work-relate<br>ed to. You mu | first aid. You must also recon<br>ed injuries and linesses that m   | d significant work re<br>eet any of the spec<br>as incident report (C | risted injuries<br>the recording        | and illnesses that are diagnosed by<br>criteria listed in 29 CFR 1904.8 thro | s work activity or job transfer, days away from work, o<br>a physician or licensed health care professional. You n<br>ugh 1004.12. Feel fee to use two lines for a single cas<br>or illness recorded on this form. If you're not sure whe | rust also<br>if you                    |                                               | Establishm                                                                                  |                                             | ing Pla                                  | A.B.C.                                  |              |               | mpa         | iny, li              | nc.          |     |
|                                                    | tify the person                                                     |                                                                       |                                         | Describe the                                                                 | ****                                                                                                                                                                                                                                      | Class                                  | ify the cas                                   |                                                                                             |                                             | ang r na                                 |                                         | State        |               |             |                      |              |     |
| (A)<br>Case No.                                    | (8)<br>Employee's Name                                              | (C)<br>Job Title<br>(e.g., Welder)                                    | (D)<br>Date of<br>injury or<br>onset of |                                                                              | (F) Describe injury or liness, parts of body affected, and object/substance that directly injured or made person il (e.o. Second degree                                                                                                   |                                        |                                               | box for each<br>outcome for t                                                               |                                             | Enter the ri<br>days the ir<br>worker wi | jured or ill                            | Check<br>(W) |               |             | olumn o<br>f iliness |              | e o |
|                                                    |                                                                     |                                                                       | ilness<br>(mo./day)                     |                                                                              | burns on right forearm from acetylene torch)                                                                                                                                                                                              | Death                                  | Days away<br>from work                        | Remaine<br>Job transfer<br>or restriction                                                   |                                             | Away<br>From<br>Work<br>(days)           | On job<br>transfer<br>or<br>restriction | š            | in Disorder   | Hpiratory   | Bound                | saring Loss  |     |
|                                                    |                                                                     |                                                                       |                                         |                                                                              |                                                                                                                                                                                                                                           | (0)                                    | (H)                                           | (i)                                                                                         | (J)                                         | (OG)                                     | (days)<br>(L)                           | (1)          | (2)           | (3)         | (4)                  | (5)          | r   |
| 021-1001                                           | Privacy Case                                                        | Baker                                                                 | 12/14/21                                | Mixing Department                                                            |                                                                                                                                                                                                                                           |                                        |                                               |                                                                                             |                                             |                                          |                                         |              |               |             |                      |              | Г   |
|                                                    |                                                                     |                                                                       |                                         |                                                                              | Page totals                                                                                                                                                                                                                               | 0                                      | 0                                             | 0                                                                                           | 0                                           | 0                                        | 0                                       | 0            | 0             | 0           | 0                    | 0            | l,  |
| e to review the<br>ormation. Pers                  | e instruction, search and gather<br>sons are not required to respon | the data needed, a<br>d to the collection of                          | nd complete<br>information u            | niess it displays a currently valid                                          | Be sure to transfer these totals                                                                                                                                                                                                          | to the                                 | Summary                                       | page (Form                                                                                  | 300A) before                                | you post                                 | it.                                     | Injury       | Skin Disorder | Respiratory | Poisoning            | Hearing Loss |     |
|                                                    | ber. If you have any commer<br>artment of Labor, OSHA Office        |                                                                       |                                         | aspects of this data collection,<br>Constitution Ave, NW, Washington,        |                                                                                                                                                                                                                                           |                                        |                                               |                                                                                             | Page                                        | 10f1                                     |                                         | (1)          | (2)           | (3)         | (4)                  | (S)          | ,   |

| 0                                | SHA 3                                                                                            | 00                                            | Lo                                | g Demo                                                                                                    | onstration                                                                                                                                                                     |                                        |                                               |                                                 |                                               |                                          |                                                   |        |               |                          |                     |              |                  |
|----------------------------------|--------------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-----------------------------------------------|-------------------------------------------------|-----------------------------------------------|------------------------------------------|---------------------------------------------------|--------|---------------|--------------------------|---------------------|--------------|------------------|
|                                  | 's Form 300<br>of Work-                                                                          |                                               |                                   | Injuries ar                                                                                               | nd IIInesses                                                                                                                                                                   | relating<br>a many<br>employ<br>inform | to employe<br>ner that profe<br>rees to the e | cts the confid<br>dent possible<br>used for occ | oust be used in<br>lentiality of<br>while the |                                          | U.                                                | Year   | part          | men                      |                     |              |                  |
| eatment beyond<br>cord work-rela | first aid. You must also reconted injuries and linesses that m                                   | d significant work in<br>seet any of the spec | risted injuries<br>ific recording | and illnesses that are diagnosed by<br>criteria listed in 29 CFR 1904.8 two                               | d work activity or job transfer, days away from work, o<br>a physician or licensed health care professional. You o<br>ugh 1904.12. Feel free to use two lines for a single cas | rust also<br>if you                    |                                               | Establishm                                      | nent name                                     |                                          | A.B.C. I                                          |        |               |                          | mB no               |              | 176              |
|                                  | ust complete an injury and lines<br>ie, call your local OSHA office t                            |                                               | ISHA Form 3                       | [1] or equivalent form for each injury                                                                    | or liness recorded on this form. If you're not sure whe                                                                                                                        | her a                                  |                                               | City                                            | Mix                                           | ing Pla                                  | ce                                                | State  |               | Per                      | nnsyl               | vania        | a                |
| Ider                             | tify the person                                                                                  |                                               |                                   | Describe the                                                                                              | case                                                                                                                                                                           | Class                                  | ify the cas                                   | e                                               |                                               |                                          |                                                   |        |               |                          |                     |              |                  |
| (A)<br>Case No.                  | (D)<br>Employee's Name                                                                           | (C)<br>Job Title<br>(e.g., Welder)            | (D)<br>Date of<br>injury or       | (E)<br>Where the event occurred<br>(e.g. Loading dock north end)                                          | (F) Describe injury or liness, parts of body affected, and object/substance that directly                                                                                      |                                        |                                               | bax for each<br>outcome for                     |                                               | Enter the ri<br>days the ir<br>worker wi | njured or ill                                     | Check  |               |                          | olumn o<br>fillness |              | e one            |
|                                  |                                                                                                  |                                               | onset of<br>illness<br>(mo./day)  |                                                                                                           | injured or made person III (e.g. Second degree<br>burns on right forearm from acetylene torch)                                                                                 | Death                                  | Days away<br>from work                        |                                                 | od at work Other recordable cases             | Away<br>From<br>Work<br>(days)           | On job<br>transfer<br>or<br>restriction<br>(days) | (g)    | Skin Disorder | Perginatory<br>Condition | Poisoning           | Hearing Loss | Al other linesse |
|                                  |                                                                                                  |                                               |                                   |                                                                                                           |                                                                                                                                                                                | (G)                                    | (H)                                           | o)                                              | (J)                                           | (X)                                      | (L)                                               | (1)    | (2)           | (3)                      | (4)                 | (5)          | (6)              |
| 021-1001                         | Privacy Case                                                                                     | Baker                                         | 12/14/21                          | Mixing Department                                                                                         | Left side groin pull / testicle pain<br>from carrying sack of flour                                                                                                            |                                        |                                               |                                                 |                                               |                                          |                                                   |        | L             |                          |                     | L            | L                |
|                                  |                                                                                                  |                                               |                                   |                                                                                                           |                                                                                                                                                                                |                                        |                                               |                                                 |                                               |                                          |                                                   |        |               |                          |                     |              |                  |
|                                  |                                                                                                  |                                               |                                   |                                                                                                           | Page totals                                                                                                                                                                    | 0                                      | 0                                             |                                                 | 0                                             | 0                                        | 0                                                 | 0      | 0             | 0                        | 0                   | 0            | 0                |
| ne to review th                  | e instruction, search and gather                                                                 | r the data needed, a                          | nd complete                       | 4 minutes per response, including<br>and review the collection of<br>inless it displays a currently valid | Be sure to transfer these totals                                                                                                                                               | to the                                 | Summary                                       | page (Form                                      | 300A) before                                  | you post                                 | i it.                                             | Injury | Skin Disorder | Respiratory<br>Condition | Poisoning           | Hearing Loss | other Bresses    |
| ontact: US Dep                   | iber. If you have any commer<br>setment of Labor, OSHA Office-<br>ot send the completed forms to | of Statistics, Room                           |                                   | aspects of this data collection,<br>Constitution Ave, NW, Washington,                                     |                                                                                                                                                                                |                                        |                                               |                                                 | Page                                          | 1 of 1                                   |                                                   | (1)    | (2)           | (3)                      | (4)                 | (5)<br>22    | (6)              |

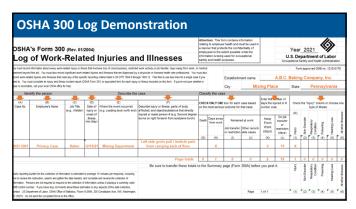
| Frequently Asked Questions                                                                                                                                                                                                                                                                                                                             |                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                        | MEMIC Safety Academy                                       |
| Q.                                                                                                                                                                                                                                                                                                                                                     |                                                            |
| How do I count weekends, holidays, or other days the employee wou anyway?                                                                                                                                                                                                                                                                              | ld not have worked                                         |
| Α.                                                                                                                                                                                                                                                                                                                                                     |                                                            |
| You must count the number of calendar days the employee was unal result of the injury or illness, regardless of whether or not the emplo to work on those day (s). Weekend days, holidays, vacation days, or included in the total number of days recorded if the employee would able to work on those days because of a work-related injury or illnes | yee was scheduled<br>other days off are<br>d not have been |
|                                                                                                                                                                                                                                                                                                                                                        |                                                            |

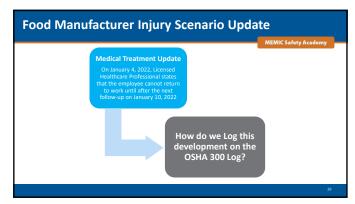


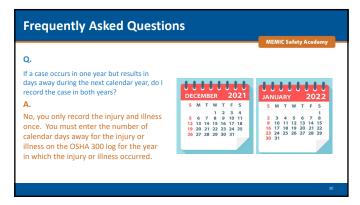


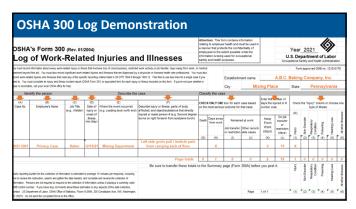


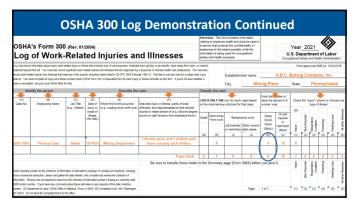
|                                                    | 's Form 30                                                                                           |                                                                          |                                                         | niuries ar                                                                                                          | nd Illnesses                                                                                                                                                                                                                                  | relating<br>a mani<br>employ<br>inform | g to employe<br>ner that prote<br>yees to the e | cts the confic<br>ident possible<br>used for occ | nust be used in<br>sentiality of<br>while the |                                | U.                                                | Year       | part          | ment                              |           | abor         |                    |
|----------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------|--------------------------------------------------|-----------------------------------------------|--------------------------------|---------------------------------------------------|------------|---------------|-----------------------------------|-----------|--------------|--------------------|
| by must record<br>eatment beyond<br>cord work-rela | information about every work<br>of first aid. You must also reco<br>ted injuries and linesses that o | related injury or line<br>and significant work-a<br>neet any of the spec | ess that involve<br>elated injuries<br>sific recording  | ves loss of consciousness, restricts<br>and linesses that are diagnosed by<br>oritoria listed in 29 CFR 1904.8 tivo | I work activity or job trensfer, days away from work, or<br>a physician or licensed health care professional. You in<br>gift 1004.12. Feel fee to use two lines for a single case<br>or liness recorded on this form. If you're not sure when | r medical<br>nust also<br>e if you     |                                                 | Establishn                                       | nent name                                     |                                | A.B.C. E                                          | For        | m appr        | oved Of                           | 48 no.    | 1218-01      |                    |
|                                                    | ie, call your local OSHA office                                                                      |                                                                          |                                                         |                                                                                                                     |                                                                                                                                                                                                                                               |                                        |                                                 | City                                             | Mix                                           | ing Pla                        | ce                                                | State      |               | Pen                               | nsyl      | vania        |                    |
| (A)                                                | tify the person                                                                                      | (C)                                                                      | (D)                                                     | Describe the                                                                                                        | (f)                                                                                                                                                                                                                                           |                                        | ify the cas                                     | e<br>box for each                                |                                               | Enter the                      |                                                   | Check      | the "in       | iuny" co                          | Aumn o    | r choose     | one                |
| Case No.                                           | Employee's Name                                                                                      | Job Title<br>(e.g., Welder)                                              | Date of<br>injury or<br>onset of<br>ilness<br>(mo./day) | Where the event occurred<br>(e.g. Loading dock north end)                                                           | Describe injury or liness, parts of body affected, and object/substance that directly injuried or made person ill (e.g. Second degree burns on right forearm from acetylene torch)                                                            | on the<br>Death                        | Days away<br>from work                          | Keman                                            | ed at work                                    | Away<br>From<br>Work<br>(days) | On job<br>transfer<br>or<br>restriction<br>(days) | (II) Arthu | Skin Disorder | Respiratory dd<br>Condition o add | Poisoning | Hearing Loss | All other linesses |
| 021.1001                                           | Privacy Case                                                                                         | Baker                                                                    | 12/14/21                                                | Mixing Department                                                                                                   | Left side groin pull / testicle pain<br>from carrying sack of flour                                                                                                                                                                           | (G)                                    | (H)<br>X                                        | (0)                                              | (J)                                           | (K)                            | (L)                                               | (1)<br>¥   | (2)           | (3)                               | (4)       | (5)          | (6)                |
| 02111001                                           | rinacy care                                                                                          | Coker                                                                    | 121421                                                  | anxing Department                                                                                                   | non carrying sack or nour                                                                                                                                                                                                                     |                                        |                                                 |                                                  |                                               | _                              |                                                   | Ĥ          |               |                                   |           |              | Т                  |
|                                                    |                                                                                                      |                                                                          | -                                                       |                                                                                                                     | Page totals                                                                                                                                                                                                                                   | 0                                      | 1                                               | 0                                                | 0                                             | 2                              | 19                                                |            | 0             | 0                                 | 0         | 0            | 0                  |
| ubic reporting t                                   |                                                                                                      |                                                                          |                                                         | 4 minutes per response, including and review the collection of                                                      | Be sure to transfer these totals                                                                                                                                                                                                              | to the                                 | Summary                                         | page (Form                                       | 300A) before                                  | you post                       | it.                                               | Injury     | Skin Disorder | Respiratory<br>Condition          | Poisoning | Hearing Loss | ther anssess       |
| formation. Pen                                     |                                                                                                      |                                                                          |                                                         | niess it displays a currently valid                                                                                 |                                                                                                                                                                                                                                               |                                        |                                                 |                                                  |                                               |                                |                                                   |            |               |                                   |           |              | ž                  |

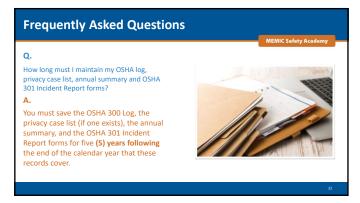


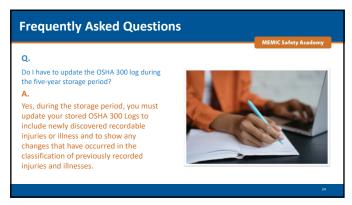




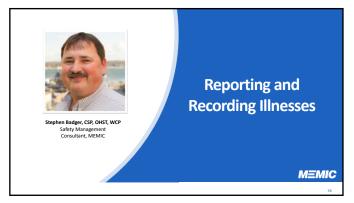


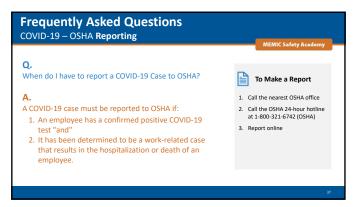


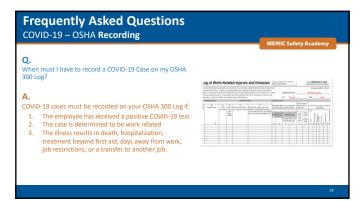








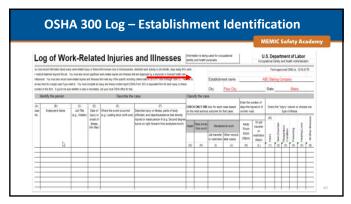


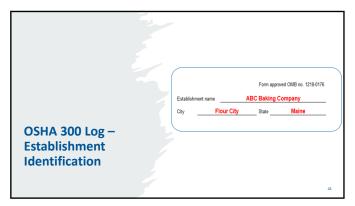


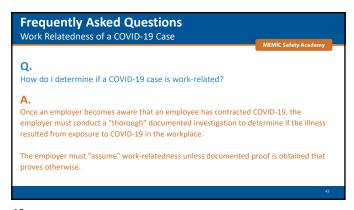
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## Donn Smith is a baker with ABC Baking Company On December 14th, 2021, Mr. Smith notifies his employer that he has contracted COVID-19 which was confirmed by his physician. The illness resulted in Mr. Smith losing 21 days of work. ABC Baking Company determined that the illness was work related since several his coworkers were diagnosed with COVID-19 a few days before Mr. Smith. This is their 13th recordable case of the year. Mr. Smith returned to work on January 5th, 2022.

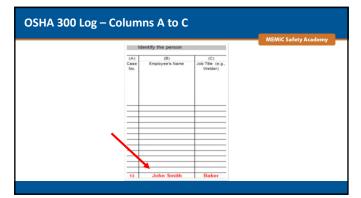
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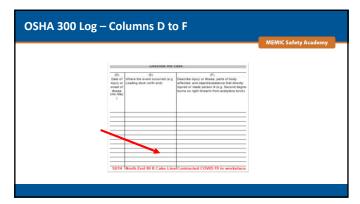




|               |                                                              |                                    |                                      | ,                                                           |                                                                                               | _              |                            |              |                          | N                                     | IEMIC                                              | Saf    | ety          | Aca                    | den                  | y            |   |
|---------------|--------------------------------------------------------------|------------------------------------|--------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------|----------------|----------------------------|--------------|--------------------------|---------------------------------------|----------------------------------------------------|--------|--------------|------------------------|----------------------|--------------|---|
|               | E HIS PECUTS WORK-PEARS BY                                   |                                    |                                      |                                                             | ZFUTT 1904 0 BYOUGH 1904 12. THE BRESD USE 580                                                |                |                            | Cstabisni    | nent name                |                                       | At                                                 | N. Dar | ing c        | ompa                   | ny .                 |              |   |
|               | case if you need to. You mu<br>ot sure whether a case is rec |                                    |                                      |                                                             | ivalent form for each injury or litness recorded on this fo                                   | en. 1          |                            | City         | Flour City               |                                       |                                                    | State  |              |                        | Maine                |              |   |
| )<br>se<br>). | (B)<br>Employee's Name                                       | (C)<br>Job Title (e.g.,<br>Welder) | injury or                            | (£)  Where the event occurred (e.g. Loading dock north end) | (F) Describe injury or illness, parts of body affected, and object/substance that directly    | CHEC<br>on the | K ONLY ONE<br>most serious | box for each | case based<br>that case: | Enter the i<br>days the i<br>worker w | njured or ill                                      | Chec   |              | gury" or<br>type of    | olumn or<br>litness: | choos        |   |
|               |                                                              |                                    | onset of<br>illness<br>(mo./day<br>) |                                                             | injured or made person II (e.g. Second degree<br>burns on right forearm from acetylene torch) | Death          | Days away<br>from work     | Job transfer | Other record             | Away<br>From<br>Work<br>(days)        | On job<br>transfer<br>or<br>restriction<br>(devs.) | (S)    | Ain Disorder | bespiratury<br>andlian | Sacrang              | learing Loss |   |
|               |                                                              |                                    |                                      |                                                             |                                                                                               | (\$)           | (H)                        | 0            | (J)                      | (8)                                   | (L)                                                | (1)    | (2)          | (3)                    | (4)                  | (5)          | ľ |
| 1             | <b>b</b>                                                     |                                    |                                      |                                                             |                                                                                               |                |                            |              |                          |                                       |                                                    |        |              |                        |                      |              | ŀ |
|               |                                                              |                                    |                                      |                                                             |                                                                                               |                |                            |              |                          |                                       |                                                    |        |              |                        |                      |              | ŀ |
| ł             |                                                              |                                    |                                      |                                                             |                                                                                               |                |                            |              |                          |                                       |                                                    |        |              |                        |                      |              |   |
| 1             |                                                              |                                    |                                      |                                                             |                                                                                               |                |                            |              |                          |                                       |                                                    |        |              |                        |                      |              | E |
|               | John Smith                                                   | Baker                              | _                                    |                                                             | Page totals                                                                                   | 0              |                            |              |                          | 0                                     |                                                    | 0      |              | 0                      |                      |              | ł |



| _               |                        |                                    | _                               |                                                           |                                                                                                                    |              |                            |              |                             | N                                      | IEMIC                                             | Safe           | ety i         | Aca                 | den           | ny             |                 |
|-----------------|------------------------|------------------------------------|---------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|--------------|----------------------------|--------------|-----------------------------|----------------------------------------|---------------------------------------------------|----------------|---------------|---------------------|---------------|----------------|-----------------|
| op              |                        | st complete an injury              | and liness                      | incident report (OSHA Form 301) or equi                   | ZY UPK 1904 IS BYOUGH 1904.12. Peer tree to use two<br>livatent form for each injury or lineas recorded on this fo |              |                            | City City    | Flour City                  |                                        | At                                                | State          | _             | -                   | ny<br>Maine   | _              | _               |
|                 | Identify the person    |                                    |                                 | Describe the o                                            | :350                                                                                                               | Class        | sify the cas               |              |                             |                                        |                                                   |                |               |                     |               |                |                 |
| L)<br>ise<br>0. | (B)<br>Employee's Name | (C)<br>Job Title (e.g.,<br>Welder) |                                 | (f) Where the event occurred (e.g. Loadno dock north end) | (F) Describe injury or illness, parts of body affected, and object/bubblance that directly                         |              | K ONLY ONE<br>most serious |              |                             | Enter the i<br>days the is<br>worker w | njured or ill                                     |                |               | jury" co<br>type of |               | choose         | one             |
|                 |                        |                                    | onset of<br>illness<br>(mo./day |                                                           | injured or made person it (i.e.g. Second degree<br>burns on right forearm from acetylene torch)                    | Death<br>(G) | Days away<br>from work     | Job transfer | Other record-<br>able cases | Away<br>From<br>Work<br>(days)         | On job<br>transfer<br>or<br>restriction<br>(days) | (S) separy (S) | Skin Disorder | Respiratory         | (E) Poisoning | @ Hearing Loss | A other thesees |
|                 |                        |                                    |                                 |                                                           |                                                                                                                    | (0)          | (6)                        | (1)          | (1)                         | (K)                                    | (6)                                               | (1)            | (40)          | (3)                 | (4)           | (5)            | (6)             |
|                 |                        |                                    |                                 |                                                           |                                                                                                                    |              |                            |              |                             |                                        |                                                   |                |               |                     |               |                | Ξ               |
|                 |                        |                                    |                                 |                                                           |                                                                                                                    |              |                            |              |                             |                                        |                                                   |                |               |                     |               |                | Ξ               |
| 3               | John Smith             | Baker                              | 12/14                           | North End 80 ft Cake Line                                 | Contracted COVID-19 in workplace                                                                                   |              |                            |              |                             |                                        |                                                   |                |               |                     |               |                |                 |



|                    |                        |                                    |                    |                                         | ins G to L                                                                                                       |       |             |                             |             | M                                       | EMIC                                    |                 |               |                     |             | y          |              |
|--------------------|------------------------|------------------------------------|--------------------|-----------------------------------------|------------------------------------------------------------------------------------------------------------------|-------|-------------|-----------------------------|-------------|-----------------------------------------|-----------------------------------------|-----------------|---------------|---------------------|-------------|------------|--------------|
| a single           |                        | complete an injury                 | and liness i       | ncident report (OSHA Form 301) or equiv | 9 CFR 1904.8 through 1904.12. Feel free to use two<br>relent form for each injury or litness recorded on this fo |       |             | Establishn<br>City          | Flour City  |                                         | At                                      | C Baki<br>State | ing C         |                     | ny<br>Maine |            | _            |
|                    |                        | , con year no                      |                    |                                         |                                                                                                                  |       |             |                             | r tour only |                                         |                                         | -               | _             |                     |             |            | =            |
|                    | dentify the person     |                                    |                    | Describe the ca                         | ise                                                                                                              | Class | ify the cas |                             |             |                                         |                                         |                 |               |                     |             |            |              |
| (A)<br>Case<br>No. | (B)<br>Employee's Name | (C)<br>Job Title (e.g.,<br>Welder) |                    |                                         | (F) Describe injury or illness, parts of body affected, and object/substance that directly                       |       |             | box for each<br>outcome for |             | Enter the n<br>days the in<br>worker wa | jured or ill                            | Check           |               | jury" ci<br>type of | olumn or    | choose     | one .        |
| 144                |                        | Treaser/                           | coset of           |                                         | injured or made person ill (e.g. Second degree                                                                   |       |             |                             |             |                                         |                                         | (11)            |               |                     |             |            | 8            |
|                    |                        |                                    | liness<br>(mo./day |                                         | burns on right forearm from acetylene torch)                                                                     | Death |             | Job transfer                | od at work  | Away<br>From<br>Work                    | On job<br>transfer<br>or<br>restriction | tulini          | Skin Disorder | Respiratory         | Boulud      | aring Loss | other liness |
|                    |                        |                                    |                    |                                         |                                                                                                                  |       |             | or restriction              | able cases  | (days)                                  | (days)                                  | 皇               | ă             | 28                  | 2           | ž          | 3            |
|                    |                        |                                    |                    |                                         |                                                                                                                  | (G)   | (H)         | 0                           | (J)         | (K)                                     | (L)                                     | (1)             | (2)           | (3)                 | (4)         | (5)        | (6)          |
| $\Box$             |                        |                                    |                    |                                         |                                                                                                                  |       |             |                             |             |                                         |                                         |                 |               |                     |             | _          | _            |
| -                  |                        |                                    |                    |                                         |                                                                                                                  |       |             |                             |             |                                         |                                         | _               |               |                     |             | _          | _            |
| -                  |                        |                                    | _                  |                                         |                                                                                                                  |       |             |                             |             |                                         |                                         | _               |               |                     |             | _          | _            |
| -                  |                        | _                                  | _                  |                                         |                                                                                                                  | -     |             |                             |             |                                         |                                         | -               | -             |                     | $\vdash$    | -          | _            |
| -                  |                        | _                                  | _                  |                                         |                                                                                                                  | _     |             |                             |             | _                                       |                                         | -               |               |                     | $\vdash$    | -          |              |
| -                  |                        |                                    |                    |                                         |                                                                                                                  |       |             |                             |             |                                         |                                         |                 |               |                     | -           | _          |              |
|                    |                        |                                    |                    |                                         |                                                                                                                  |       |             |                             |             |                                         |                                         |                 |               |                     |             |            |              |
|                    |                        |                                    |                    |                                         |                                                                                                                  |       |             |                             |             |                                         |                                         |                 |               |                     |             |            | _            |
|                    |                        |                                    |                    |                                         |                                                                                                                  |       |             |                             |             |                                         |                                         |                 |               |                     |             |            |              |
|                    |                        |                                    |                    |                                         |                                                                                                                  |       |             |                             |             |                                         |                                         |                 |               |                     |             |            | _            |
|                    |                        |                                    |                    |                                         |                                                                                                                  |       |             |                             |             | L                                       |                                         |                 |               |                     |             |            | _            |
| 13                 | John Smith             | Baker                              | 12/14              | North End 80 ft Cake Line               | Contracted COVID-19 in workplace                                                                                 | -     | X           |                             |             | 21                                      | _                                       | -               |               |                     |             | _          | _            |
| _                  |                        |                                    |                    |                                         | Page totals                                                                                                      | 0     | 1           | 0                           | 0           | 21                                      | 0                                       | 0               | 0             | 0                   | 0           | 0          | 0            |

| OSHA 300 Log – C | olι   | ımn                    | s G t        | o L                    |                                |                                                   |     |             | Academy |  |
|------------------|-------|------------------------|--------------|------------------------|--------------------------------|---------------------------------------------------|-----|-------------|---------|--|
|                  | CHECK |                        | box for each |                        | Enter the ridays the is        | njured or ill                                     | MEM | ic Safety i | Academy |  |
|                  | Death | Days away<br>from work | Job transfer | Other recordable cases | Away<br>From<br>Work<br>(days) | On job<br>transfer<br>or<br>restriction<br>(days) |     |             |         |  |
|                  | (G)   | (H)                    | (1)          | (J)                    | (K)                            | (L)                                               |     |             |         |  |
|                  |       |                        |              |                        |                                |                                                   |     |             |         |  |
|                  |       | X                      | 0            | 0                      | 21                             | 0                                                 |     |             |         |  |
|                  |       |                        |              |                        |                                |                                                   |     |             |         |  |

| _                                                                                                                                                                                            |                        |                                    |                                |                                                                  |                                                                                                                                                                                       | _        |                        |                                                                      |     | M                                                             | Safety Academy        |                         |           |                          |          |           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------------------------|--------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|------------------------|----------------------------------------------------------------------|-----|---------------------------------------------------------------|-----------------------|-------------------------|-----------|--------------------------|----------|-----------|--|
| Four must also record work-related injuries and linesses that meet any of the specific recording criteria listed in                                                                          |                        |                                    |                                |                                                                  |                                                                                                                                                                                       |          | Establishn             | Establishment name                                                   |     | ABC Baking Company                                            |                       |                         |           |                          |          |           |  |
| a single case if you need to. You must complete an injury and illness incident report (DSHA Form 301) or you've not sure whether a case is recondable, call your local OSHA office for help. |                        |                                    |                                | valent form for each injury or litness recorded on this form. If |                                                                                                                                                                                       |          | City                   | Flour City                                                           |     | State                                                         | State Maine           |                         |           |                          |          |           |  |
| le                                                                                                                                                                                           | dentify the person     |                                    |                                | Describe the c                                                   | ase                                                                                                                                                                                   | Classi   | sify the cas           | se                                                                   |     |                                                               |                       |                         |           |                          |          |           |  |
| (A)<br>Case<br>No.                                                                                                                                                                           | (B)<br>Employee's Name | (C)<br>Job Title (e.g.,<br>Welder) |                                | Loading dock north end)                                          | (F) Describe injury or liness, parts of body affected, and object/substance that directly injured or made person ill (e.g. Scoond degree barns on right forearm from acetylene torch) |          |                        | NLY ONE box for each case based<br>at serious outcome for that case: |     | Enter the number of<br>days the injured or ill<br>worker was: |                       | Check the "injury" colu |           |                          |          |           |  |
|                                                                                                                                                                                              |                        |                                    | onset of<br>liness<br>(mo./day |                                                                  |                                                                                                                                                                                       |          | Days away<br>from work |                                                                      |     | Away On job<br>From transfer                                  |                       | (M)                     | norder    | took u                   | 2        | amptoss   |  |
|                                                                                                                                                                                              |                        |                                    | ,                              |                                                                  |                                                                                                                                                                                       |          |                        | or restriction                                                       |     | Work<br>(days)                                                | restriction<br>(days) | Injury                  | San Disor | Respiratory<br>Condition | 2        | £         |  |
| $\rightarrow$                                                                                                                                                                                |                        | +                                  |                                |                                                                  |                                                                                                                                                                                       | (G)      | (8)                    | (0)                                                                  | (3) | (K)                                                           | (L)                   | (1)                     | (2)       | (3)                      | (4)      | (5)       |  |
| $\exists$                                                                                                                                                                                    |                        | _                                  |                                |                                                                  |                                                                                                                                                                                       |          | _                      |                                                                      |     |                                                               |                       |                         |           |                          | =        | 7         |  |
| $\exists$                                                                                                                                                                                    |                        |                                    |                                |                                                                  |                                                                                                                                                                                       | =        |                        |                                                                      |     |                                                               | 7                     |                         |           |                          | 二        | $\pm$     |  |
| -                                                                                                                                                                                            |                        | +                                  | _                              |                                                                  |                                                                                                                                                                                       | $\vdash$ | _                      | _                                                                    | _   |                                                               |                       |                         |           |                          | +        | +         |  |
| $\exists$                                                                                                                                                                                    |                        | _                                  | =                              |                                                                  |                                                                                                                                                                                       | $\vdash$ | =                      |                                                                      |     |                                                               |                       |                         |           |                          | 7        | 7         |  |
| $\equiv$                                                                                                                                                                                     |                        |                                    |                                |                                                                  |                                                                                                                                                                                       |          |                        |                                                                      |     |                                                               |                       |                         |           |                          | $\pm$    | $\pm$     |  |
| -                                                                                                                                                                                            |                        | _                                  | _                              |                                                                  |                                                                                                                                                                                       | H        | ⊢                      | _                                                                    |     |                                                               |                       | F-                      |           |                          | =        | 4         |  |
| $\exists$                                                                                                                                                                                    |                        |                                    |                                |                                                                  |                                                                                                                                                                                       |          |                        |                                                                      |     |                                                               |                       |                         |           |                          | $\equiv$ | $\exists$ |  |
| 13                                                                                                                                                                                           | John Smith             | Baker                              | 12/14                          | North End 80 ft Cake Line                                        | Contracted COVID-19 in workplace<br>Page totals                                                                                                                                       |          | X                      |                                                                      |     | 21                                                            | 0                     | 0                       | 0         | 0                        |          | 0         |  |

| OSHA 300 Log – Column | s M  | 1           | to                       | M         | 5            |                  |                      |
|-----------------------|------|-------------|--------------------------|-----------|--------------|------------------|----------------------|
|                       |      |             |                          |           |              |                  | MEMIC Safety Academy |
|                       |      |             |                          |           |              |                  |                      |
|                       | Chec | k the "I    | njury" c                 | olumn o   | or choos     | e one            |                      |
|                       | (M)  | SinDisorder | Respiratory<br>Candition | Poisoning | Hearing Loss | W other linesses |                      |
|                       | (1)  | (5)         | (3)                      | (4)       | (S)          | (6)              |                      |
|                       |      | E           |                          |           |              |                  | •                    |
|                       |      | =           |                          |           |              |                  |                      |
|                       |      | E           |                          |           |              |                  |                      |
|                       | =    | $\equiv$    |                          |           |              |                  |                      |
|                       | 0    | 0           | 0                        | 0         | 0            | X<br>1           |                      |
|                       | 鱼    | Disorder    | Spiratory<br>Condition   | Poisoning | amgless      | linesses.        |                      |
|                       |      |             |                          |           | - 30         |                  | 1                    |

|                    | OSHA 300 Log – Completed Log          |                                    |       |                                                                  |                                                                                                                                                                                    |              |                        |                                |                                         |                                                         |                                                   |          |               |             |               |              |                   |  |
|--------------------|---------------------------------------|------------------------------------|-------|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|------------------------|--------------------------------|-----------------------------------------|---------------------------------------------------------|---------------------------------------------------|----------|---------------|-------------|---------------|--------------|-------------------|--|
|                    | Identify the person Describe the case |                                    |       |                                                                  |                                                                                                                                                                                    |              | Classify the case      |                                |                                         |                                                         |                                                   |          |               |             |               |              |                   |  |
| (A)<br>Case<br>No. | (B)<br>Employee's Name                | (C)<br>Job Title (e.g.,<br>Welder) |       | (E)<br>Where the event occurred (e.g.<br>Loading dock north end) | (F) Describe injary or liness, parts of body affected, and object/substance hat directly injured or made person life g. Second degree burns on right forearm from acetylene troch) | CHEC         | K ONLY ONE             | box for each<br>soutcome for   | Enter the n<br>days the in<br>worker wa | Check the "injury" column or choose one type of liness: |                                                   |          |               |             |               |              |                   |  |
|                    |                                       |                                    |       |                                                                  |                                                                                                                                                                                    | Death<br>(G) | Days away<br>from work | Job transfer<br>or restriction |                                         | Away<br>From<br>Work<br>(days)                          | On job<br>transfer<br>or<br>restriction<br>(days) | Lujus    | Skin Disorder | Respiratory | Boisoning (4) | Hearing Loss | Al other illnesse |  |
| 1                  | Jane Smith                            | Admin Sect.                        | 1/12  | Employee Parking Lot                                             | Slipped and struck left knee on ground                                                                                                                                             | (6)          | (8)                    | (I)<br>X                       | (J)                                     | (N)                                                     | (L)<br>8                                          | (1)<br>X | (2)           | (3)         | (4)           | (5)          | (6)               |  |
| 2                  | Susan Doe                             | Mixer                              | 2/22  |                                                                  | Slipped and struck left knee on ground<br>Slipped striking head on sink                                                                                                            |              |                        | ^                              | X                                       |                                                         | 0                                                 | x        |               |             | -             | -            | $\vdash$          |  |
| 3                  | Bill Sender                           | Baker                              | 4/4   |                                                                  | Strained shoulder when lifting mixer                                                                                                                                               |              | X                      |                                | _^                                      | 2                                                       | 4                                                 | x        |               |             | Н             | -            | Н                 |  |
| 4                  | Justin Time                           | Shipper                            | 6/14  |                                                                  | Spider in package bit left index finger                                                                                                                                            |              | _^                     | X                              |                                         | -                                                       | 3                                                 | x        |               |             | Н             |              | Н                 |  |
| 5                  | Mary Contrary                         | Taster                             | 7/8   |                                                                  | Food poisoning from rancid whey                                                                                                                                                    |              | X                      | - "                            |                                         | 4                                                       | _                                                 | -        |               |             | Х             |              | Н                 |  |
| 6                  | Ole Cole                              | Sweeper                            | 7/11  |                                                                  | Occupation Hearing Loss Right Ear                                                                                                                                                  |              |                        |                                | X                                       |                                                         |                                                   |          |               |             | _             | X            | Н                 |  |
| 7                  | Dusty Miller                          | Sifter                             | 9/13  | Flour Preparation                                                | Rash developed on both hands                                                                                                                                                       |              | X                      |                                |                                         | 14                                                      | 10                                                |          | X             |             |               | <u> </u>     | т                 |  |
| 8                  | Dan Washer                            | Dishwasher                         | 9/16  | Kitchen Sink - West Side                                         | Left shoulder pain moving pans                                                                                                                                                     |              | Х                      |                                |                                         |                                                         | 22                                                | Х        |               |             |               | <b></b>      | П                 |  |
| 9                  | Candy Toothaker                       | Taster                             | 11/29 |                                                                  | Tripped over pallet and hit right knee                                                                                                                                             |              |                        |                                | X                                       |                                                         | 4                                                 | X        |               |             |               |              |                   |  |
| 10                 | David Sleeper                         | Baker                              | 12/6  | North End 80 ft Cake Line                                        | Contracted COVID-19 in workplace                                                                                                                                                   |              | X                      |                                |                                         | 17                                                      |                                                   |          |               |             |               | $\Box$       | X                 |  |
| 11                 | Ben Tired                             | Mixer                              | 12/9  | North End 80 ft Cake Line                                        | Contracted COVID-19 in workplace                                                                                                                                                   |              | X                      |                                |                                         | 22                                                      |                                                   |          |               |             |               | П            | X                 |  |
| 12                 | Pat Butter                            | Froster                            | 12/11 | North End 80 ft Cake Line                                        | Contracted COVID-19 in workplace                                                                                                                                                   |              | X                      |                                |                                         | 18                                                      |                                                   | _        |               |             |               |              | X                 |  |
| 13                 | John Smith                            | Baker                              | 12/14 | North End 80 ft Cake Line                                        | Contracted COVID-19 in workplace                                                                                                                                                   |              | X                      |                                |                                         | 21                                                      |                                                   | _        |               |             |               |              | X                 |  |
|                    |                                       |                                    |       |                                                                  | Page totals                                                                                                                                                                        | 0            | 8                      | 2                              | 3                                       | 98                                                      | 51                                                | 6        | 1             | 0           | 1             | 1            | 4                 |  |
|                    |                                       |                                    |       |                                                                  |                                                                                                                                                                                    |              |                        |                                |                                         |                                                         |                                                   |          |               |             |               |              |                   |  |



