



SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES

Year 20 _____

Michigan Department of Labor and Economic Growth
Michigan Occupational Safety and Health Administration (MIOSHA)
Form Approved OMB No. 1218-0176

All establishments covered by Public Law of 1970 (P.O. 91-596) and Michigan Occupational Safety and Health Act 154, P.A. 1974, Part 11, Michigan Administrative Rule for Recording and Reporting of Injuries and Illnesses, must complete this Summary page, even if no work-related injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate before completing this summary. You may be fined for failure to comply.

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the Log. If you had no cases, write "0."

Employees, former employees, and their representatives have the right to review the MIOSHA Form 300 in its entirety. They also have limited access to the MIOSHA Form 301 or its equivalent. See Part 11, R408.22135 Rule 1135, in MIOSHA's recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
_____	_____	_____	_____
(G)	(H)	(I)	(J)

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
_____	_____
(K)	(L)

Injury and Illness Types

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

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

Public reporting burden for this collection of information is estimated to average 50 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: Michigan Department of Labor & Economic Growth, MIOSHA, MTSD, 7150 Harris Dr., P.O. Box 30643, Lansing MI 48909-8143 • (517) 322-1848 • Do not send completed forms to this office.

Establishment Information

YOUR ESTABLISHMENT NAME		
STREET		
CITY	STATE	ZIP CODE
INDUSTRY DESCRIPTION (e.g., Manufacture of motor truck trailers)		
STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN (E.G., SIC 3715)		

Employment Information

ANNUAL AVERAGE NUMBER OF EMPLOYEES
TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR

Sign Here

Knowingly falsifying this document may result in a fine.

I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.

COMPANY EXECUTIVE	TITLE
PHONE NUMBER ()	DATE



INJURY AND ILLNESS INCIDENT REPORT

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

*Michigan Department of Labor and Economic Growth
Michigan Occupational Safety and Health Administration (MIOSHA)*

Form Approved OMB No. 1218-0176

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

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

According to Public law of 1970 (P.L. 91-596) and Michigan Occupational Safety and Health Act 154, P.A. 1974, Part 11, Michigan Administrative Rule for Recording and Reporting of Injuries and Illnesses, you must keep this form on file for 5 years following the year to which it pertains. You may be fined for failure to comply.

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

	Information about the employee	Information about the cases
<p>COMPLETED BY</p> <hr/> <p>TITLE</p> <hr/> <p>PHONE () DATE / /</p>	1. FULL NAME	10. CASE NUMBER FROM THE LOG (Transfer the case number from the Log after you record the case.)
	2. STREET	11. DATE OF INJURY OR ILLNESS / /
	CITY STATE ZIP CODE	12. TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM
	3. DATE OF BIRTH / /	13. TIME OF EVENT <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Check if time cannot be determined
	4. DATE HIRED / /	14. WHAT WAS THE EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED? Describe the activity as well as the tools, equipment, or material the employee was using. Be specific. Examples: "Climbing a ladder while carrying roofing materials"; "Spraying chlorine from hand sprayer"; "Daily computer key-entry."
5. <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	15. WHAT HAPPENED? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."	
Information about the physician or other health care professional		
6. NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL		
7. IF TREATMENT WAS GIVEN AWAY FROM THE WORKSITE, WHERE WAS IT GIVEN?		
FACILITY		
STREET		
CITY STATE ZIP CODE		
8. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? <input type="checkbox"/> YES <input type="checkbox"/> NO		
9. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
16. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," "sore." Examples: "Strained Back"; "Chemical Burn on Hand"; "Carpal Tunnel Syndrome."		
17. WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE? Examples: "Concrete Floor"; "Chlorine"; "Radial Arm Saw." If this question does not apply to the incident, leave it blank.		
18. IF THE EMPLOYEE DIED, WHEN DID DEATH OCCUR? DATE OF DEATH / /		

Public reporting burden for this collection of information is estimated to average 22 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB number. If you have any comments about these estimates or any other aspects of this data collection, including suggestions for reducing this burden, contact: Michigan Department of Labor & Economic Growth, MIOSHA, MTSD, 7150 Harris Dr., P.O. Box 30643, Lansing MI 48909-8143 • (517) 322-1848 • Do not send completed forms to this office.