

Summary of Work-Related Injuries and Illnesses

Form approved OMB no. 1218-0176

All establishments covered by Part 1904 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.

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 OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR Part 1904.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases

Table with 4 columns: Total number of deaths (0), Total number of cases with days away from work (0), Total number of cases with job transfer or restriction (0), Total number of other recordable cases (0). Includes labels (G), (H), (I), (J).

Number of Days

Table with 2 columns: Total number of days away from work (0), Total number of days of job transfer or restriction (0). Includes labels (K), (L).

Injury and Illness Types

Table with 2 columns: Total number of... (M) and categories (1) Injuries, (2) Skin disorders, (3) Respiratory conditions, (4) Poisonings, (5) Hearing loss, (6) All other illnesses, all with value 0.

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

Public reporting burden for this collection of information is estimated to average 50 minutes per response, including time to review the 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: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

((Date of Injury>="01/01/2024" AND Date of Injury<="12/31/2024") AND Firm Code="RML HD2 ") AND All Employees

Establishment Information

Form fields for Establishment Information: Your establishment name (RML HD2), Street, City, State, Zip, Industry description (e.g. Manufacture of motor truck trailers), Standard Industrial Classification (SIC), if known (e.g., 336212), OR North American Industrial Classification (NAICS), if known. (e.g., 336212)

Employment Information

(If you don't have these figures, see the Worksheet on the back of this page to estimate.)

Form fields for 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.

Form fields for signature: Company executive, Title, Phone, Date