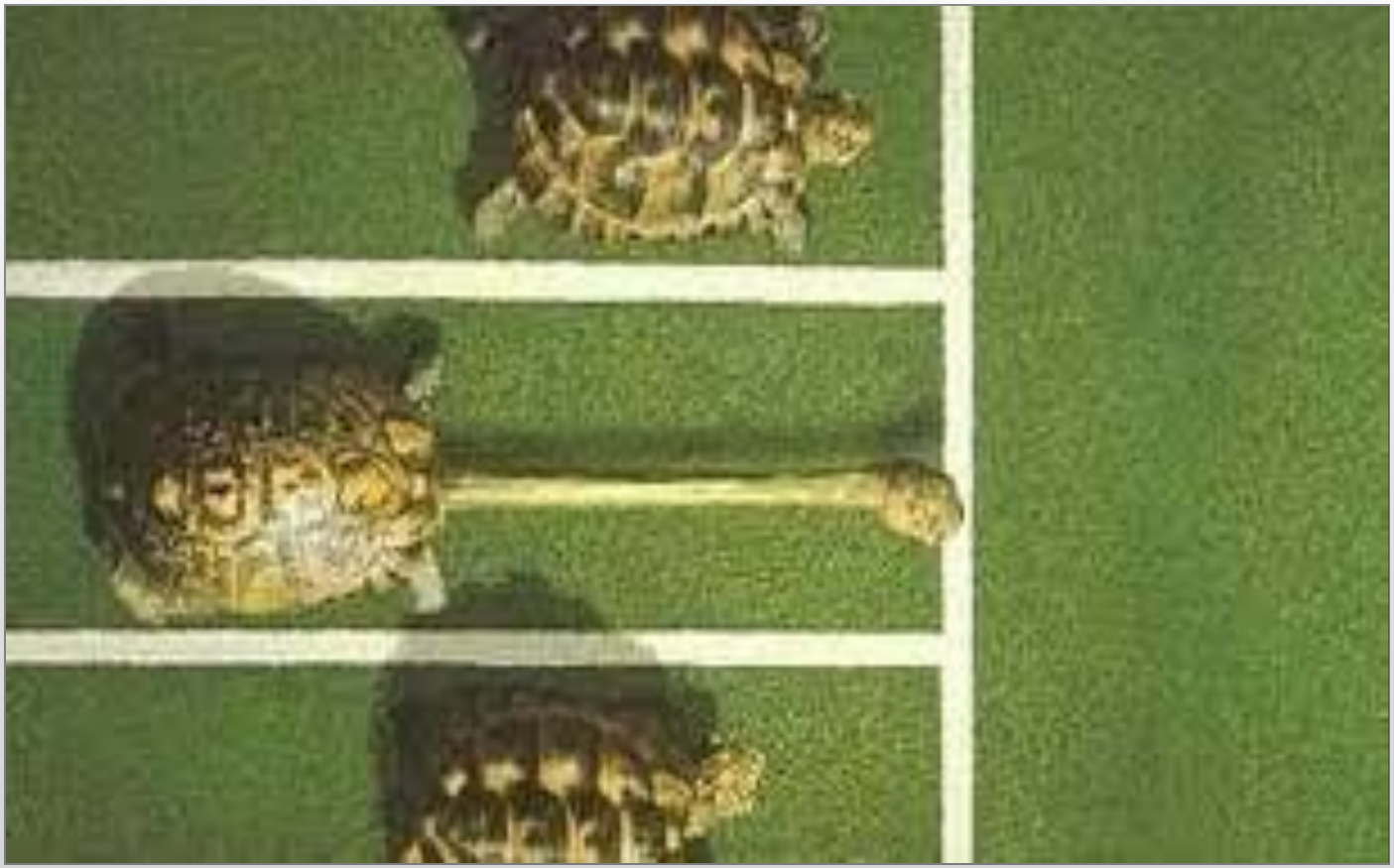
SOUTH CAROLINA
STATE ACCIDENT FUND

SAFETY AND LOSS CONTROL Services

Loss Prevention and Cost Containment

“*Don’t break your neck for SAFETY*”



SOUTH CAROLINA

STATE ACCIDENT FUND

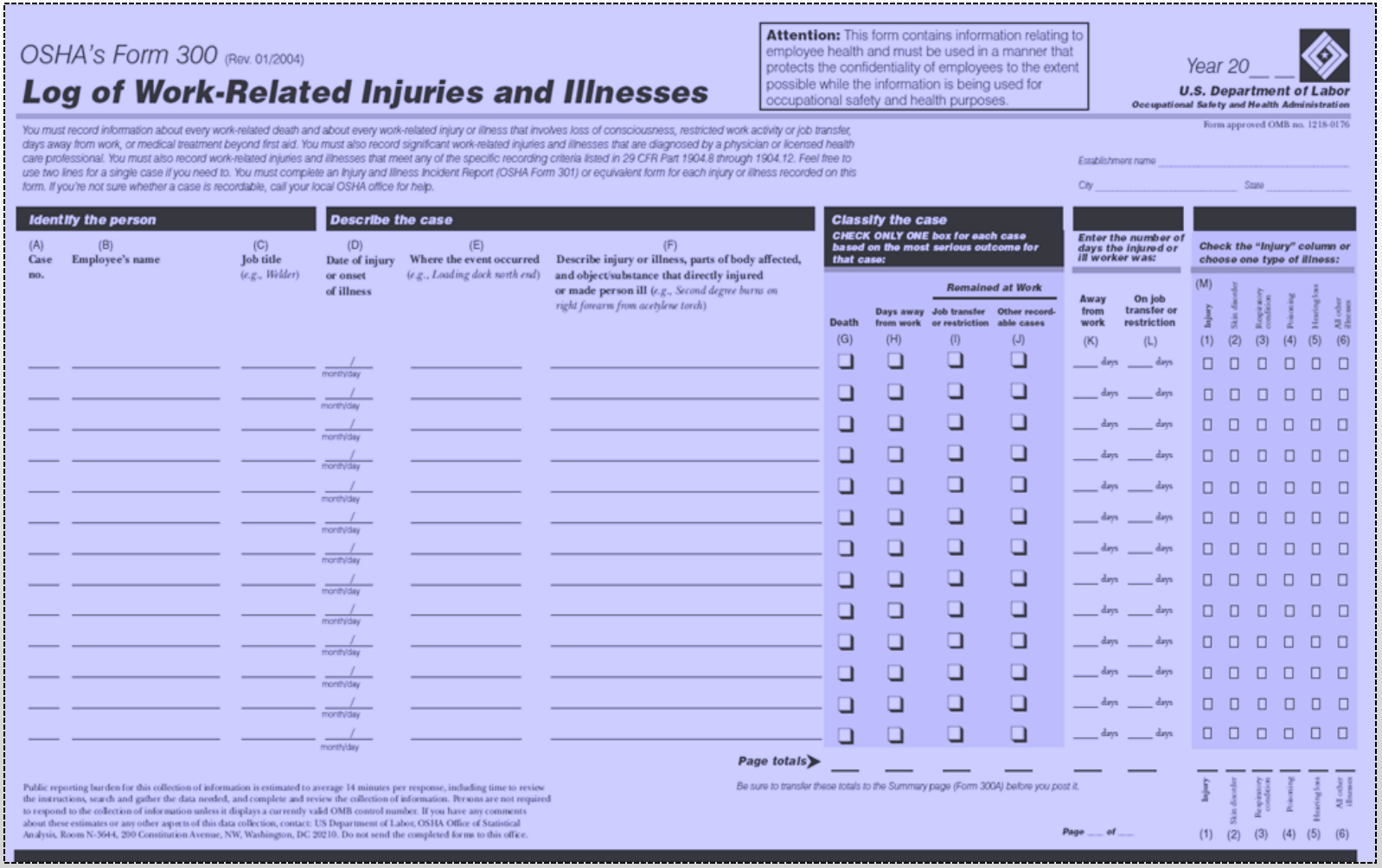
SAFETY AND LOSS CONTROL Services

Loss Prevention and Cost Containment

Products
Think
Safety
First!

www.saf.sc.gov

"OSHA Recordkeeping Forms"
Form 300



OSHA's Form 300 (Rev. 01/2004)

Log of Work-Related Injuries and Illnesses

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

Year 20__ __

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Establishment name _____

City _____ State _____

Identify the person			Describe the case			Classify the case: CHECK ONLY ONE box for each case based on the most serious outcome for that case:				Enter the number of days the injured or ill worker was:		Check the "Injury" column or choose one type of illness:					
(A) Case no.	(B) Employee's name	(C) Job title (e.g., Welder)	(D) Date of injury or onset of illness	(E) Where the event occurred (e.g., Loading dock north end)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g., Second degree burns on right forearm from acetylene torch)	(G) Death	(H) Days away from work	(I) Remained at Work: Job transfer or restriction	(J) Remained at Work: Other recordable cases	(K) Away from work	(L) On job transfer or restriction	(M) Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)
____			__/__ month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____			__/__ month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____			__/__ month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____			__/__ month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____			__/__ month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____			__/__ month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____			__/__ month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____			__/__ month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____			__/__ month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____			__/__ month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____			__/__ month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____			__/__ month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____			__/__ month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
Page totals ➤						___	___	___	___	___	___	___	___	___	___	___	___

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

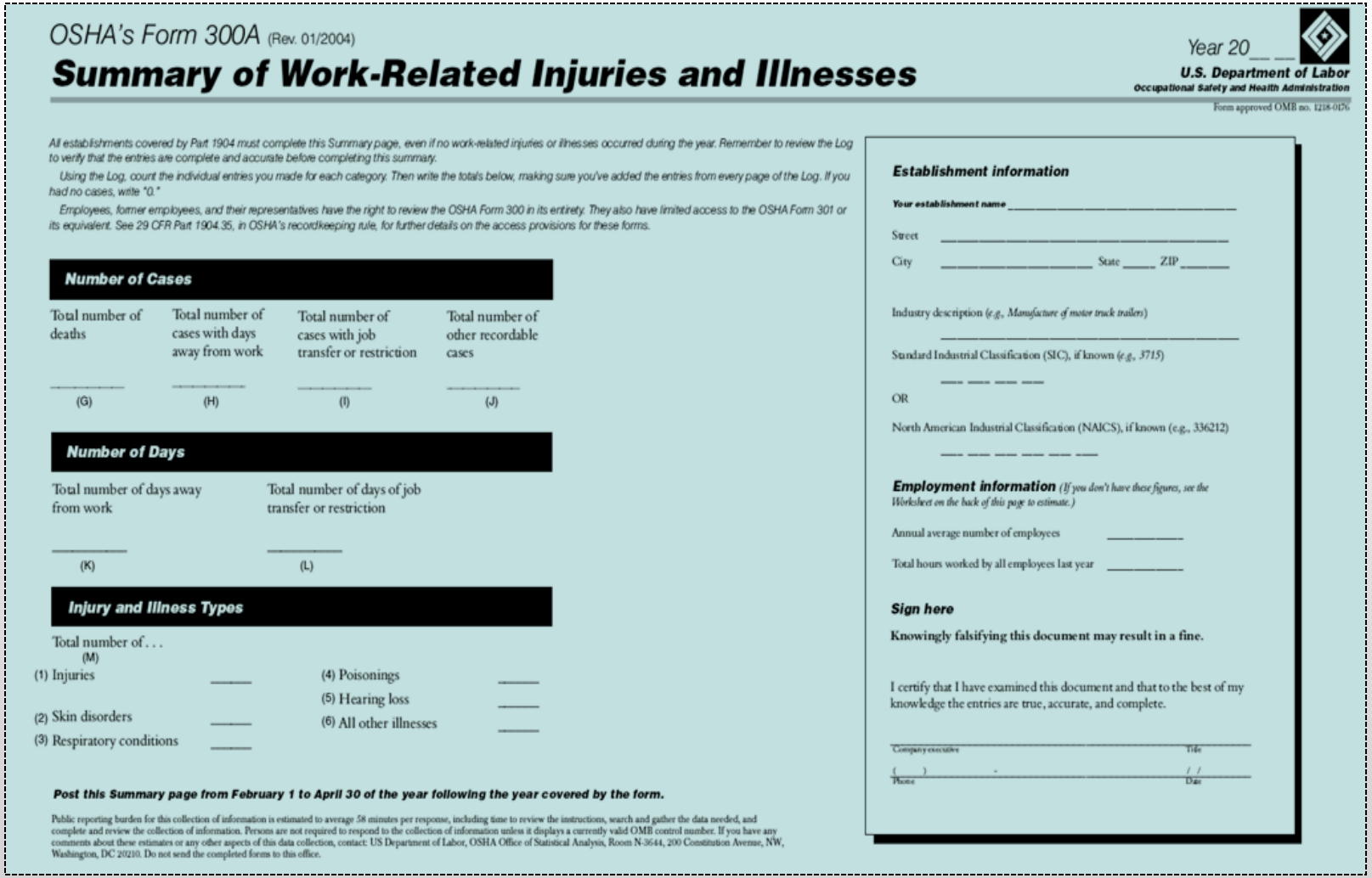
Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information 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 Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Page ___ of ___

Injury (1) Skin disorder (2) Respiratory condition (3) Poisoning (4) Hearing loss (5) All other illnesses (6)

"OSHA Recordkeeping Forms"

Form 300A



OSHA's Form 300A (Rev. 01/2004)

Summary of Work-Related Injuries and Illnesses

Year 20__ __

U.S. Department of Labor
Occupational Safety and Health Administration

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

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

Number of Days

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

Injury and Illness Types

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

Post this 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 58 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 Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Establishment information

Your establishment name _____

Street _____

City _____ State ____ ZIP _____

Industry description (*e.g., Manufacture of motor truck trailers*)

_____

Standard Industrial Classification (SIC), if known (*e.g., 3715*)

___ ___ ___ ___

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.*)

Annual average number of employees _____

Total hours worked by all employees last year _____

Sign here

Knowingly falsifying this document may result in a fine.

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

_____ _____
Company executive Title

( ) - / /
Phone Date

"OSHA Recordkeeping Forms"

FORM 301 ***

OSHA's Form 301

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.

U.S. Department of Labor
Occupational Safety and Health Administration

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 OSHA develop a picture of the extent and severity of work-related incidents.

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

According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

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

Completed by _____

Title _____

Phone (_____)_____–_____ Date ___/___/___

Information about the employee

1) Full name _____

2) Street _____

City _____ State _____ ZIP _____

3) Date of birth ___/___/___

4) Date hired ___/___/___

5) ☐ Male
☐ Female

Information about the physician or other health care professional

6) Name of physician or other health care professional _____

_____

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

Facility _____

Street _____

City _____ State _____ ZIP _____

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

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

Information about the case

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

11) Date of injury or illness ___/___/___

12) Time employee began work _____ AM / PM

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

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

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

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

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

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

Public reporting burden for this collection of information is estimated to average 22 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Persons are not required to respond to the collection of information unless it displays a current valid OMB control number. If you have any comments about this estimate or any other aspects of this data collection, including suggestions for reducing this burden, contact: US Department of Labor, OSHA Office of Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Changes to Reporting Requirements!

As of January 1, 2015, all employers must report :

- All work-related fatalities within 8 hrs (30 days)
- All work-related inpatient hospitalizations, amputations, and losses of an eye within 24 hours

Employers should call **(803) 896-7672**. This number is answered 24 hrs a day, 7 days a week!

If you must report…

- **Establishment name**
- **Location of work-related event**
- **Time of work-related event**
- **Type of reportable event (fatality, in-patient hospitalization, amputation or loss of an eye)**
- **Number of employees who suffered the event**
- **Names of employees who suffered the event**
- **Contact person and phone number**
- **Brief description of the work-related incident**

Changes to Reporting Requirements!

Do not have to report event if it:

- Resulted from a motor vehicle accident on a public street or highway; except in a construction work zone

- Occurred on commercial or public transportation system (plane, subway, bus, ferry, street car, light rail, train)
- Occurred more than 30 days after incident (fatality) or more than 24 hrs after (in-patient hospitalization, amputation, or loss of eye)

Changes to Reporting Requirements!

Do not have to report event if it:

- Is in-patient hospitalization for diagnostic testing or observation only
- Is in-patient for a heart attack, unless the attack resulted from a work-related incident

Common Training Classes

Accident Investigation
BloodBorne Pathogens
General Safety
Heat Related Illnesses
Lockout / Tagout
OSHA 300, 300A, 301
Safety Committees
Workplace Violence

Back Injury Prevention
Confined Space
Hazard Communication
Ladder Safety
Office Safety
Safety Attitude
Slips, Trips, and Falls
Special Requests

Video Library www.saf.sc.gov

SAFETY ASSESSMENT

- Initial Meeting
- Discuss your Program
- Form a Plan
- Inspections – "Mock"/Ergo
- Assist with Corrections, Trainings, etc.

“Mock Inspection” 1

1910

.304(g)(6)(vi)(c)(5)
.305(b)(1)(ii)
.305(b)(2)(i)
.333(a)
.304(g)(5)
.334(a)(3)(i)
.335(a)(1)(i)

1926

404(b)(1)(ii)
.405(b)(2)
.405(b)(1)

Electrical Citations

"Mock Inspection" 2

1910

.212(a)(1)
.215(b)(9)
.212(a)(5)
.219(e)(3)(i)
.219(c)(2)(i)
.334(a)(3)(i)
.335(a)(1)(i)

1926

404(b)(1)(ii)
.405(b)(2)
.405(b)(1)

Guarding Citations

NUMBER

“Mock Inspection” 4

1910
.23(c)(1)
1926
.451(g)(4)(i)
.501(b)(1)
.453(b)(2)(v)
.451(c)(1)(ii)
.501(b)(13)
.501(b)(10)
.451(e)(1)
.501(b)(4)

Fall-Related Citations

“Mock Inspection” 5

Earth-Moving Equipment/ Forklift Citations

1926

.602(a)(9)(i)

.601(b)(4)

.602(a)(9)(ii)

.602(c)(1)(vi)

1910

.178(l)(1)(i)

.178(l)(4)(iii)

3

“Mock Inspection” Others

- General Duty Clause **1.12(a)**
- Lock Out Tag Out **1910.147**
- Flammable Liquids **1926.152**
- Air Compressors **1910.242**
- Excavations **1926.652**
- Handheld Power Tools **1910.212**

SAFETY SELLS

For Sale
By Owner
MUST SELL
LOST JOB CAN'T PAY
MTG. WIFE LEFT, TOOK
DOG. HOUSE A GEM,
EXCEPT FOR ASBESTOS
BEST OFFER
ID# BIOBYMN

SOUTH CAROLINA
STATE ACCIDENT FUND

P.O. Box 102100 Columbia, SC 29221

THANK YOU!

Barney Derrick
bderrick@saf.sc.gov
803-896-5935