Mason County
Injury and Illness Incident Report

OSHA 301 Substitute

Employee # _______

This form must be completed by every Mason County employee who experiences an occupational accident or illness, whether or not injuries were sustained. The purpose of this form is to ensure immediate documentation and communication of an accident/incident to the department, Human Resources, Risk Manager, and others involved in general safety and health standards. This form must be completed within 24 hours of the accident and submitted to the supervisor, copy should be forwarded to the Human Resources Department. **Human Resources must receive the completed report within seven calendar days from the date of accident/incident to comply with new OSHA regulations and documentation requirements**.

Employee Name_______________________________________Department___________________________

Job Title____ Date of Birth______________Female [ ] Male [ ]

Home Address____

Date of injury or illness_________ Time of event________ AM/PM Time began work _____________AM/PM

Location where incident occurred (i.e. building or address)_______________________________________ Hours worked per/day____ #days per wk____

Date reported________________ at ___________AM/PM Reported to ________________________________

Supervisor's Name______________________________ Witness______________________________________

Activity performed just prior to the injury or illness____

Description of how the injury or illness occurred (include type of duties performed at the time and any tools or machinery involved.

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Injury or illness Description (i.e. strained back, burn, carpal tunnel)____

Part(s) of body injured_____________________________What object or substance directly caused the harm?

(i.e. concrete floor, hammer,chemical)_________________________Medical treatment necessary? Yes [ ] No [ ]

Name of physican____________________________Clinic or Hospital________________________________

Emergency room treatment? Yes [ ] No [ ] Hospitalized over night as inpatient? Yes [ ] No [ ]

Will there be time loss from work? Yes [ ] No [ ] Dates of time loss: ______________ to ______________

Light duty work? Yes [ ] No [ ] _____ _ _ ___ __ days. Restricted hours of work? Yes [ ] No [ ]

_____________________________________ ______________________

Employee Signature Date

Supervisor & Human Resources must complete reverse side

Supervisor's Remarks and/or Recommendations

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______________________ ______________________

Signature Date

Investigator's Remarks and/or Recommendation

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______________________ ______________________

Signature Date

Human Resources use only

Received & Completed by ______________________ Title ______________________

Date received ______________________ Phone ______________________

Address of attending physician or hospital ______________________

Employee's date of hire ______________________ Did the employee die? Yes [ ] No [ ]

Case number for the OSHA log ______________________