OSHA 301 Form

Completed by: _____
Title: _____
Phone: _____
Date: _____

Information about the employee:
Full name: _____
Street/City/State/ZIP: _____
_____
Date of birth: _____/_____/_____
Date hired: _____/_____/_____

Sex:

- ☐ Male
- ☐ Female
- ☐ Other

Information about the physician/health care professional:
Full name: _____

If the treatment was provided away from the workplace fill out the details:
Facility: _____
Street: _____
City: _____

Was the employee treated in the emergency room?

- ☐ Yes
- ☐ No

Was the employee hospitalized overnight?

- ☐ Yes
- ☐ No

Information about the incident:
Date of injury/illness: _____/_____/_____
Time the employee began work: _____ AM/PM
Time of the incident: _____ AM/PM

Description of the activity before the incident occurred:

Description of the incident:

Description of the injury/illness:

Description of the object/substance that directly harmed the employee:

If the employee died, when did the death occur?
Date _____/_____/_____