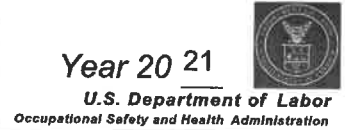


# OSHA's Form 300 (Rev. 04/2004)

## Log of Work-Related Injuries and Illnesses

**Note: You can type input into this form and save it.** Because the forms in this recordkeeping package are "fillable/writable" PDF documents, you can type into the input form fields and then save your inputs using the free Adobe PDF Reader. In addition, the forms are programmed to auto-calculate as appropriate.

**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.



Form approved OMB no. 1218-0176

**Please 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.
- Significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional.
- Work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12.

**Reminders:**

- 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.
- Feel free to use two lines for a single case if you need to.
- Complete the 5 steps for each case.

Establishment name **Allstate Home Health Services**

City **Las Vegas** State **NV**

**Step 1. Identify the person**

**Step 2. Describe the case**

**Step 3. Classify the case**

**Step 4.**

**Step 5.**

SELECT ONLY ONE circle based on the most serious outcome:

Enter the number of days the injured or ill worker was:

Select one column:

(A) Case no.	(B) Employee's name	(C) Job title (e.g., Welder)	(D) Date of injury or onset of illness (e.g., 2/10)	(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)
Reset			/		
Reset			month / day		
Reset			/		
Reset			month / day		
Reset			/		
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Reset			/		
Reset			month / day		

Death (G)	Remained at Work			Away from work (K)	On job transfer or restriction (L)
	Days away from work (H)	Job transfer or restriction (I)	Other recordable cases (J)		
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___ days	___ days
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___ days	___ days
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___ days	___ days
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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___ days	___ days
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___ days	___ days

(M)	Illness					
	Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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.

**Add a Form Page**

Page totals **0 0 0 0 0 0**

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

**0 0 0 0 0 0**  
 Injury Skin disorder Respiratory condition Poisoning Hearing loss All other illnesses  
 (1) (2) (3) (4) (5) (6)

OSHA's Form 300A (Rev. 04/2004)

Summary of Work-Related Injuries and Illnesses

Note: You can type input into this form and save it. Because the forms in this recordkeeping package are "fillable/writable" PDF documents, you can type into the input form fields and then save your inputs using the free Adobe PDF Reader.

Year 20 21



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
0	0	0	0
(G)	(H)	(I)	(J)

Number of Days	
Total number of days away from work	Total number of days of job transfer or restriction
0	0
(K)	(L)

Injury and Illness Types			
Total number of . . . (M)			
(1) Injuries	0	(4) Poisonings	0
(2) Skin disorders	0	(5) Hearing loss	0
(3) Respiratory conditions	0	(6) All other illnesses	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 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 Allstate HOme Health Services

Street 6206 W. Desert Inn Rd. Ste B

City Las Vegas State NV Zip 89146

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

North American Industrial Classification (NAICS), if known (e.g., 336212)

**Employment information** (If you don't have these figures, see the Worksheet on the next page to estimate.)

Annual average number of employees 4

Total hours worked by all employees last year 1,920.00

**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.

[Signature] Title \_\_\_\_\_

Company executive  
Phone 702-399.8880 Date 01/25/2023

**Reset**