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Safety Plan Review Sign-In Sheet

For: ________________________________

Our Plan has been reviewed by:

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<th>Reviewer’s Name (print)</th>
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Signature of Reviewer ______________________ Date ______________________

Sign below to indicate that you have read and reviewed the plan listed above and that you have been given the opportunity to ask questions to management to ensure a complete understanding of the employer’s plan:

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Multiple Safety Plan Review Sign-In Sheet

For: Safety and Health Plan (Injury and Illness Prevention Program), BBP Exposure Control Plan, Hazard Communication Program, and Emergency Action Plan
(Use this form if you wish to record reviewing all four Safety Plans at once)

The four plans listed above have been reviewed by:

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<th>Reviewer’s Name (print)</th>
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Signature of Reviewer ___________________________  Date ___________________________

Sign below to indicate that you have read and reviewed the plans listed above and that you have been given the opportunity to ask questions to management to ensure a complete understanding of the employer’s plans:

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# Safety Training Record

Complete this attendance sheet as a documented record of attendance for any safety trainings that do not have their own separate, dedicated attendance records. All affected employees must be in attendance, if possible. This record should be retained for a minimum of three years.

<table>
<thead>
<tr>
<th>Date of Training</th>
<th>Person or Position Conducting Training</th>
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## Qualification or Title

**Employees in Attendance**

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Signature of Person Conducting Meeting

Title

Date
Employee Orientation Guidelines

Provided below is a checklist of the most common items to be covered in the initial workplace orientation provided for most healthcare workers. This checklist is limited to information specifically required by OSHA, CDC guidelines, or other regulatory agencies, and does not, therefore, include information related to administrative policies, human resources matters, workplace benefits, etc., that may also be required by an employer for new worker orientation.

Training

Many OSHA Standards have specific requirements for training that must be completed before a worker is ever placed into service. For a full overview, see OSHA publication 2254 available at https://www.osha.gov/Publications/osha2254.pdf. Common topics typically requiring training for healthcare workers are:

- Bloodborne Pathogens
- Hazard Communication, including:
  - Hazardous chemicals in your workplace
  - Safety Data Sheets location and use
  - Pictograms
  - Safety Data Sheet format
  - Elements required for manufacturers to use on labels
- Personal Protective Equipment
- Emergency Preparedness/Evacuation Plans
  - Fire extinguisher policy
  - Emergency Action Plan
  - Fire Prevention Plan
  - Portable Fire Extinguisher use
- Use of eyewash or drench shower
- Use of first aid kit and spill kit
- Use of engineering controls such as sharps containers, medical waste containers, scalp blade removers, fume hoods, etc.
- Biohazardous Waste
- DOT hazardous material training related to Biohazardous Waste
- Respiratory Protection (if applicable)
- Formaldehyde (if applicable)
- LASER training (if applicable)
- Aerosol Transmissible Diseases (if applicable; California only)
- Any other OSHA or other government agency’s required training as applicable.
Written Plans/Programs

Be sure to also train affected workers in the various written Safety Plans that may be required for your workplace:

- Bloodborne Pathogens Exposure Control Plan
  Be sure to cover training on:
  - Annual review and update requirements
  - Annual evaluation and implementation of safer devices
  - Annual solicitation of non-managerial input
  - Written certification of hazard assessment for selection of PPE
  - Housekeeping schedule
- Hazard Communication Program
- Emergency Preparedness Plan
- Safety and Health Plan (if applicable) (also called Injury and Illness Prevention Program in some states)
- Respiratory Protection Program (if applicable)
- Aerosol Transmissible Diseases Exposure Control Plan/Protocols (if applicable; California only)

Labor Laws

The contents of various required labor law posters should also be covered in new worker orientation:

- OSHA – Occupational Safety and Health Administration
- USERRA – Uniformed Services Employment and Reemployment Act
- Federal Minimum Wage
- Polygraph Protection
- EEOC – Equal Employment Opportunity Commission
- FMLA – Family Medical Leave Act
- NLRB – National Labor Relations Board (as applicable)
- State labor law posters (for your convenience, see websites of various poster vendors such as www.postercompliance.com for a listing of what may be required in your State).
Medical Issues

In addition to formal trainings and informing workers about any written Safety Plans/Programs and Labor Laws, be sure to also comply with OSHA required medical immunization or surveillance/clearance issues for affected workers such as:

- Hepatitis B vaccination offered
- HBV Vaccination records or Declination form on file in employee confidential medical records
- Initial/Annual notice to employees of their right to access their own medical records (may be accomplished with a posting on Labor Law bulletin board, etc.)
- Tuberculosis testing
- Respirator medical clearance (as applicable)
- Respirator annual fit testing (as applicable)
- Aerosol Transmissible Disease immunizations (if applicable; California only).

Signature of Person Conducting Orientation  Title

Employee Signature  Date
Unsafe Practices Notification Form

This form should be completed and placed in an employee’s personnel file.

Name of Employee ___________________________________________ Date of Hire ____________________

Job Title or Assignment _______________________________________

Violation (give full explanation)

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Date Time Place of Violation

Explanation of Employee

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Witness Interviewed

Was employee previously warned verbally for the violation? ❑ Yes ❑ No

Has employee had previous written warning for this violation? ❑ Yes ❑ No

Date of: Verbal Warning 1st Written Warning 2nd Written Warning 3rd Written Warning

Recommended Action (check appropriate)

❑ Suspension From To Termination date
❑ Probation ❑ Suspensions ❑ Termination

I have just read this warning and understand the rule I have violated. I also understand the General Safety Rules of our facility.

Employee Signature ___________________________ Date __________________

Verification of Corrective Action Completed ___________________________ Date __________________
Employee Safety Suggestion Form

Employees who wish to provide a safety suggestion or to report an unsafe workplace condition or practice should do so using this form. Please give this completed form to your OSHA Coordinator for follow-up.

I am concerned about

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

I think this is the cause or contributing factor

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

My suggestion for improving safety is

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Has this matter been reported to the employer?  □ Yes  □ No

Reviewed by ___________________________ Date ___________________________

Corrective Action Taken By ___________________________ Date ___________________________

Employee Name (optional) ___________________________ Date ___________________________

The employer will investigate any reports or questions as required by our Safety and Health Plan and will advise the employee who submitted the safety suggestion or the workers in the area of the employer’s response.
Safety Meeting Attendance Record

Facility Name

Complete this attendance sheet prior to beginning monthly or quarterly safety meetings. Keep completed sheet for recordkeeping. This record should be retained for a minimum of three years. Attach separate sheet if additional names are needed.

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Person or Position Conducting Meeting

Employees In Attendance

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Signature of Person Conducting Meeting | Title | Date
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**Instructions for OSHA's Recordkeeping forms**

*Forms for Recording Work-Related Injuries and Illnesses*

**An Overview: Recording Work-Related Injuries and Illnesses**

General instructions for filling out the forms in this package and definitions of terms you should use when you classify your cases as injuries or illnesses.

**How to Fill Out the Log**

An example to guide you in filling out the log properly.

**Log of Work-Related Injuries and Illnesses**

Several pages of the log (but you may make as many copies of the log as you need.) Notice that the log is separate from the summary.

**Summary of Work-Related Injuries and Illnesses**

Removable Summary pages for easy posting at the end of the year. Note that you post the Summary only, not the log.

**Worksheet to Help You Fill Out the Summary**

A worksheet for figuring the average number of employees who worked for your establishment and the total number of hours worked.

**OSHA's 301: Injury and Illness Incident Report**

A copy of the OSHA 301 to provide details about the incident. You may make as many copies as you need or use an equivalent form.

If you have any questions visit us online www.osha.gov or call your local OSHA office.

**Recording Work-Related Injuries and Illnesses**

The Occupational Safety and Health (OSHA) Act of 1970 requires certain employers to prepare and maintain records of work-related injuries and illnesses. Use these definitions when you classify cases on the Log. OSHA’s recordkeeping regulation (see 29 CFR Part 1904) provides more information about the definitions below.

The Log of Work-Related Injuries and Illnesses (Form 300) is used to classify work-related injuries and illnesses and to note the extent and severity of each case. When an incident occurs, use the log to record specific details about what happened and how it happened. The Summary — a separate form (Form 300A) — shows the totals for the year in each category. At the end of the year, post the Summary in a visible location so that your employees are aware of the injuries and illnesses occurring in their workplace.

Employers must keep a Log for each establishment or site. If you have more than one establishment, you must keep a separate Log and Summary for each physical location that is expected to be in operation for one year or longer.

Note that your employees have the right to review your injury and illness records.

Cases listed on the Log of Work-Related Injuries and Illnesses are not necessarily eligible for workers’ compensation or other insurance benefits. Listing a case on the Log does not mean that the employer or worker was at fault or that an OSHA Standard was violated.

When is any injury or illness considered work-related? An injury or illness is considered work-related if an event or exposure in the work environment caused or contributed to the condition or significantly aggravated a preexisting condition. Work-relatedness is presumed for injuries and illnesses resulting from events or exposures occurring in the workplace, unless an exception specifically applies. The work environment includes the establishment and other locations where one or more employees are working or are present as a condition of their employment.
Which work-related injuries and illnesses should you record?
Record those work-related injuries and illnesses that result in:
- death,
- loss of consciousness,
- days away from work,
- restricted work activity or job transfer, or
- medical treatment beyond first aid.

You must also record work-related injuries and illnesses that are significant (as defined below) or meet any of the additional criteria listed below.

You must record any significant work-related injury or illness that is diagnosed by a physician or other licensed healthcare professional. You must record any work-related case involving cancer, chronic irreversible disease, a fractured or cracked bone, or a punctured eardrum.

What are the additional criteria?
You must record the following conditions when they are work-related:
- any needlestick injury or cut from a sharp object that is contaminated with another person’s blood or other potentially infectious material;
- any case requiring an employee to be medically removed under the requirements of an OSHA health Standard;
- tuberculosis infection as evidenced by a positive skin test or diagnosis by a physician or other licensed healthcare professional after exposure to a known case of active tuberculosis.
- an employee’s hearing test (audiogram) reveals 1) that the employee has experienced a Standard Threshold Shift (STS) in hearing in one or both ears (averaged at 2000, 3000, and 4000 Hz) and 2) the employee’s total hearing level is 25 decibels (dB) or more above audiometric zero (also averaged at 2000, 3000, and 4000 Hz) in the same ear(s) as the STS.

What is medical treatment?
Medical treatment includes managing and caring for a patient for the purpose of combating disease or disorder. The following are not considered medical treatments and are NOT recordable:
- visits to a doctor or healthcare professional solely for observation or counseling;
- diagnostic procedures, including administering prescription medications that are used solely for diagnostic purposes;
- and any procedure that can be labeled first aid. (See below for more information about first aid.)

What is first aid?
If the incident required only the following types of treatment, consider it first aid. Do NOT record the case if it involves only:
- using non-prescription medications at non-prescription strength;
- administering tetanus immunizations;
- cleaning, flushing, or soaking wounds on the skin surface;
- using wound coverings, such as bandages, BandAids™, gauze pads, etc., or using SteriStrips™ or butterfly bandages.
- using hot or cold therapy;

What do you need to do?
1. Within 7 calendar days after you receive information about a case, decide if the case is recordable under the OSHA recordkeeping requirements.
2. Determine whether the incident is a new case or a recurrence of an existing one.
3. Establish whether the case was work-related.
4. If the case is recordable, decide which form you will fill out as the injury and illness incident report.
5. You may use OSHA’s 301: Injury and Illness Incident Report or an equivalent form. Some state workers compensation, insurance, or other reports may be acceptable substitutes, as long as they provide the same information as the OSHA 301.

How to work with the Log
1. Identify the employee involved, unless it is a privacy concern case.
2. Identify when and where the case occurred.
3. Describe the case, as specifically as you can.
4. Classify the seriousness of the case by recording the most serious outcome associated with the case, with column G (Death) being the most serious and column J (Other recordable cases) being the least serious.
5. Identify whether the case is an injury or illness. If the case is an injury, check the injury category. If the case is an illness, check the appropriate illness category.
• using any totally non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc.;
• using temporary immobilization devices while transporting an accident victim (splints, slings, neck collars, or back boards);
• drilling a fingernail or toenail to relieve pressure, or draining fluids from blisters;
• using eye patches;
• using simple irrigation or a cotton swab to remove foreign bodies not embedded in or adhered to the eye;
• using irrigation, tweezers, cotton swab, or other simple means to remove splinters or foreign material from areas other than the eye;
• using finger guards;
• using massages;
• drinking fluids to relieve heat stress.

How do you decide if the case involved restricted work?
Restricted work activity occurs when, as the result of a work-related injury or illness, an employer or healthcare professional keeps, or recommends keeping, an employee from doing the routine functions of his or her job or from working the full workday that the employee would have been scheduled to work before the injury or illness occurred.

How do you count the number of days of restricted work activity or the number of days away from work?
Count the number of calendar days the employee was on restricted work activity or was away from work as a result of the recordable injury or illness. Do not count the day on which the injury or illness occurred in this number. Begin counting days from the day after the incident occurs. If a single injury or illness involved both days away from work and days of restricted work activity, enter the total number of days for each. You may stop counting days of restricted work activity or days away from work once the total of either or the combination of both reaches 180 days.

Under what circumstances should you NOT enter the employee’s name on the OSHA Form 300?
You must consider the following types of injuries or illnesses to be privacy concern cases:
• an injury or illness to an intimate body part or to the reproductive system,
• an injury or illness resulting from a sexual assault,
• a mental illness,
• a case of HIV infection, hepatitis, or tuberculosis,
• a needlestick injury or cut from a sharp object that is contaminated with blood or other potentially infectious material, and
• other illnesses, if the employee independently and voluntarily requests that his or her name not be entered on the log.

You must not enter the employee’s name on the OSHA 300 Log for these cases. Instead, enter “privacy case” in the space normally used for the employee’s name. You must keep a separate, confidential list of the case numbers and employee names for the establishment’s privacy concern cases so that you can update the cases and provide information to the government if asked to do so.

If you have a reasonable basis to believe that information describing the privacy concern case may be personally identifiable even though the employee’s name has been omitted, you may use discretion in describing the injury or illness on both the OSHA 300 and 301 forms. You must enter enough information to identify the cause of the incident and the general severity of the injury or illness, but you do not need to include details of an intimate or private nature.

What if the outcome changes after you record the case?
If the outcome or extent of an injury or illness changes after you have recorded the case, simply draw a line through the original entry or, if you wish, delete or white-out the original entry. Then write the new entry where it belongs. Remember, you need to record the most serious outcome for each case.
Classifying injuries
An injury is any wound or damage to the body resulting from an event in the work environment.

**Examples:** Cut, puncture, laceration, abrasion, fracture, bruise, contusion, chipped tooth, amputation, insect bite, electrocution, or a thermal, chemical, electrical, or radiation burn. Sprain and strain injuries to muscles, joints, and connective tissues are classified as injuries when they result from a slip, trip, fall or other similar accidents.

**Classifying illnesses**

Skin diseases or disorders
Skin diseases or disorders are illnesses involving the worker’s skin that are caused by work exposure to chemicals, plants, or other substances.

**Examples:** Contact dermatitis, eczema, or rash caused by primary irritants and sensitizers or poisonous plants, oil acne, friction blisters, chrome ulcers, inflammation of the skin.

Respiratory conditions
Respiratory conditions are illnesses associated with breathing hazardous biological agents, chemicals, dusts, gases, vapors, or fumes at work.

**Examples:** Silicosis, asbestosis, pneumonitis, pharyngitis, rhinitis or acute congestion, farmer’s lung, beryllium disease, tuberculosis, occupational asthma, reactive airways dysfunction syndrome (RADS), chronic obstructive pulmonary disease (COPD), hypersensitivity pneumonitis, toxic inhalation injury, such as metal fume fever, chronic obstructive bronchitis, and other pneumoconioses.

Poisoning
Poisoning includes disorders evidenced by abnormal concentrations of toxic substances in blood, other tissues, other bodily fluids, or the breath that are caused by the ingestion or absorption of toxic substances into the body.

**Examples:** Poisoning by lead, mercury, cadmium, arsenic, or other metals, poisoning by carbon monoxide, hydrogen sulfide, or other gases, poisoning by benzene, benzoil, carbon tetrachloride, or other organic solvents, poisoning by insecticide sprays, such as parathion or lead arsenate, poisoning by other chemicals, such as formaldehyde.

Hearing Loss
Noise-induced hearing loss is defined for recordkeeping purposes as a change in hearing threshold relative to the baseline audiogram of an average of 10 dB or more in either ear at 2000, 3000 and 4000 hertz, and the employee’s total hearing level is 25 decibels (dB) or more above audiometric zero (also averaged at 2000, 3000, and 4000 hertz) in the same ear(s).

**All other illnesses**

All other occupational illnesses.

**Examples:** Heatstroke, sunstroke, heat exhaustion, heat stress and other effects of environmental heat, freezing, frostbite, and other effects of exposure to low temperatures, decompression sickness, effects of ionizing radiation (isotopes, x-rays, radium), effects of nonionizing radiation (welding flash, ultra-violet rays, lasers), anthrax, bloodborne pathogenic diseases, such as AIDS, HIV, hepatitis B or hepatitis C, brucellosis, malignant or benign tumors, histoplasmosis, coccidioidomycosis.

**When must you post the Summary?**
You must certify and post the Summary only — not the Log — by February 1 of the year following the year covered by the form, and keep it posted until April 30 of that year.

**How long must you keep the Log and Summary on file?**
You must keep the Log and Summary for 5 years following the year to which they pertain.

**Do you have to send these forms to OSHA at the end of the year?**
No. You do not have to send the completed forms to OSHA unless specifically asked to do so.
Calculating Injury and Illness Incidence Rates

What is an incidence rate?
An incidence rate is the number of recordable injuries and illnesses occurring among a given number of full-time workers (usually 100 full-time workers) over a given period of time (usually one year). To evaluate your firm’s injury and illness experience over time or to compare your firm’s experience with that of your industry as a whole, you need to compute your incidence rate. Because a specific number of workers and a specific period of time are involved, these rates can help you identify problems in your workplace and/or progress you may have made in preventing work-related injuries and illnesses.

How do you calculate an incidence rate?
You can compute an occupational injury and illness incidence rate for all recordable cases or for cases that involved days away from work from work for your firm quickly and easily. The formula requires that you follow instructions in paragraph (a) below for the total recordable cases or those in paragraph (b) for cases that involved days away from work, and for both rates the instructions in paragraph (c).

(a) To find out the total number of recordable injuries and illnesses that occurred during the year, count the number of line entries on your OSHA Form 300, or refer to the OSHA Form 300A and sum the entries for columns (G), (H), (I), and (J).

(b) To find out the number of injuries and illnesses that involved days away from work, count the number of line entries on your OSHA Form 300 that received a check mark in column (H), or refer to the entry for column (H) on the OSHA Form 300A.

(c) The number of hours all employees actually worked during the year. Refer to OSHA Form 300A and optional worksheet to calculate this number.

You can compute the incidence rate for all recordable cases of injuries and illnesses using the following formula:
Total number of injuries and illnesses x 200,000 ÷ Number of hours worked by all employees = Total recordable case rate.

(The 200,000 figure in the formula represents the number of hours 100 employees working 40 hours per week, 50 weeks per year would work, and provides the standard base for calculating incidence rates.)

You can compute the incidence rate for recordable cases involving days away from work, days of restricted work activity or job transfer (DART) using the following formula:
(Number of entries in column H + Number of entries in column I) x 200,000 ÷ Number of hours worked by all employees = DART incidence rate

You can use the same formula to calculate incidence rates for other variables such as cases involving restricted work activity (column (I) on Form 300A), cases involving skin disorders (column (M-2) on Form 300A), etc. Just substitute the appropriate total for these cases, from Form 300A, into the formula in place of the total number of injuries and illnesses.

What can I compare my incidence rate to?
The Bureau of Labor Statistics (BLS) conducts a survey of occupational injuries and illnesses each year and publishes incidence rate data by various classifications (e.g., by industry, by employer size, etc.). You can obtain these published data at www.bls.gov/iif or by calling a BLS Regional Office.
How to Fill Out the Log

The Log of Work-Related Injuries and Illnesses is used to classify work-related injuries and illnesses and to note the extent and severity of each case. When an incident occurs, use the Log to record specific details about what happened and how it happened.

If your company has more than one establishment or site, you must keep separate records for each physical location that is expected to remain in operation for one year or longer.

We have given you several copies of the Log in this package. If you need more than we provided, you may photocopy and use as many as you need.

The Summary — a separate form — shows the work-related injury and illness totals for the year in each category. At the end of the year, count the number of incidents in each category, and transfer the totals from the Log to the Summary. Then post the Summary in a visible location so that your employees are aware of injuries and illnesses occurring in their workplace.

You don’t post the Log. You post only the Summary at the end of the year.
At the end of the year, OSHA requires you to enter the average number of employees and the total hours worked by your employees on the summary. If you don’t have these figures, you can use the information on this page to estimate the numbers you will need to enter on the Summary page at the end of the year.

### How to figure the average number of employees who worked for your establishment during the year:

1. **Add** the total number of employees your establishment paid in all pay periods during the year. Include all employees: full-time, part-time, temporary, seasonal, salaried, and hourly.

   \[ \text{The number of employees paid in all pay periods} = \]

2. **Count** the number of pay periods your establishment had during the year. Be sure to include any pay periods when you had no employees.

   \[ \text{The number of pay periods during the year} = \]

3. **Divide** the number of employees by the number of pay periods.

   \[ \frac{\text{The number of employees paid in all pay periods}}{\text{The number of pay periods during the year}} = \]

4. **Round** the answer to the next highest whole number. Write the rounded number in the blank marked **Annual average number of employees**.

### How to figure the total hours worked by all employees:

Include hours worked by salaried, hourly, part-time and seasonal workers, as well as hours worked by other workers subject to day to day supervision by your establishment (e.g., temporary help services workers).

Do not include vacation, sick leave, holidays, or any other non-work time, even if employees were paid for it. If your establishment keeps records of only the hours paid or if you have employees who are not paid by the hour, please estimate the hours that the employees actually worked.

If this number isn’t available, you can use this optional worksheet to estimate it.

### Optional Worksheet

**Find** the number of full-time employees in your establishment for the year.

\[ \text{Number of employees paid} = 830 \]

**Multiply** by the number of work hours for a full-time employee in a year.

\[ \text{Number of pay periods} = 26 \]

\[ 830 \times 26 = 21,580 \]

This is the number of full-time hours worked.

**Add** the number of any overtime hours as well as the hours worked by other employees (part-time, temporary, seasonal).

\[ 830 \times 26 + 152 = 21,732 \]

**Round** the answer to the next highest whole number. Write the rounded number in the blank marked **Total hours worked by all employees last year**.

\[ 21,732 \text{ rounds to } 21,730 \]

---

**Worksheet to Help You Fill Out the Summary**

At the end of the year, OSHA requires you to enter the average number of employees and the total hours worked by your employees on the summary. If you don’t have these figures, you can use the information on this page to estimate the numbers you will need to enter on the Summary page at the end of the year.
OSHA Records in Our Workplace  
*(workplace of 10 or fewer employees)*

<table>
<thead>
<tr>
<th>OSHA Recordkeeping Administrator</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>is responsible for maintaining our OSHA recordkeeping.</td>
<td></td>
</tr>
</tbody>
</table>

Since we employ ten or fewer employees, our facility is exempt from the requirement to maintain OSHA Injury and Illness Recordkeeping. The Occupational Safety and Health Administration does not require us to record workplace injuries or illness on the OSHA 300 series of logs.

We are committed to workplace safety and health, and we will maintain files on accident reports and investigations in addition to employee training records.

For workplaces not located in California with ten or fewer employees, this completes your Safety and Health Plan/Injury and Illness Prevention Program. Please proceed to the next safety plan.

For workplaces located in California with ten or fewer employees, please proceed to page 3.1-3.89 for information concerning the California Aerosol Transmissible Diseases Standards requirements.

For workplaces with 11 or more employees, please continue on the next page.
OSHA Records in Our Workplace
(for partially exempt industries/professions)

OSHA Recordkeeping Administrator is responsible for maintaining our OSHA recordkeeping.

Since our type of workplace industry/profession appears on the Partially Exempt list, and our workplace is not in HI, MN, WA, and PR, we are exempt from the requirement to maintain OSHA Injury and Illness Recordkeeping. The Occupational Safety and Health Administration does not require us to record workplace injuries or illness on the OSHA 300 series of logs.

We are committed to workplace safety and health and we will maintain files on accident reports and investigations, in addition to employee training records.

For non-California workplaces in industries/professions appearing on the Partially Exempt list (except for the exceptions noted for HI, MN, WA and PR), this completes your Safety and Health Plan/Injury and Illness Prevention Program. Please proceed to the next safety plan. For California workplaces, please proceed to page 3.1-3.89 for information concerning the California Aerosol Transmissible Diseases Standard.

If your workplace employs more than ten employees and your type of industry/profession does not appear on the Partially Exempt list, then your workplace is not exempted and is required to maintain the OSHA 300 series of logs. Please continue to the next page for information on the required recordkeeping, and then, if your workplace is located in California, proceed to page 3.1-3.89 for information on the California Aerosol Diseases Standard.
OSHA’s Form 300:
Log of Work-Related Injuries and Illnesses

*Please note 1904.29(b)(6)-(9) mandates that certain injuries and illnesses are considered privacy concern cases. Injuries and illnesses involving intimate body parts or the reproductive system, resulting from a sexual assault, mental illnesses, HIV infection, Hepatitis or tuberculosis, needlestick injuries and cuts from sharp objects contaminated with blood or other potentially infectious material and other illnesses that an employee independently requests be left off the log. In such a case you must enter “privacy case” in the space for the employee name and keep a separate confidential list of the case numbers and names. Please see regulations for additional details.
OSHA’s Form 300 (Rev. 01/2004)
Log of Work-Related Injuries and Illnesses

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.

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.

### Identify the person

<table>
<thead>
<tr>
<th>(A) Case no.</th>
<th>(B) Employee’s name</th>
<th>(C) Job title (e.g., Welder)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

### Describe the case

<table>
<thead>
<tr>
<th>(D) Date of injury or onset of illness</th>
<th>(E) Where the event occurred (e.g., Loading dock with rad)</th>
<th>(F) Describe injury or illness, parts of body affected, and object/substance that directly injured</th>
</tr>
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<tbody>
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</tbody>
</table>

### Classify the case

**CHECK ONLY ONE box for each case based on the most serious outcome for that case:**

- **Death**
- **Days away from work**
- **Job transfer or restriction**
- **Other recordable cases**

**Remained at Work**

- **Away from work**
- **On job transfer or restriction**

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

- **Death**
- **Days away from work**
- **Job transfer or restriction**
- **Other recordable cases**

**Check the “Injury” column or choose one type of illness:**

- **Injury**
- **Skin disorder**
- **Respiratory condition**
- **Poisoning**
- **Hearing loss**
- **All other illnesses**

---

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.

---

**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.

---

**Page totals**

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

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**Page** of **Page**
Cal/OSHA’s Form 300:

Log of Work-Related Injuries and Illnesses

*Please Note that OSHA mandates that certain injuries and illnesses are considered privacy concern cases. Injuries and illnesses involving intimate body parts or the reproductive system, resulting from a sexual assault, mental illnesses, HIV infection, Hepatitis or tuberculosis, needlestick injuries and cuts from sharp objects contaminated with blood or other potentially infectious material and other illnesses that an employee independently requests be left off the log. In such a case you must enter “privacy case” in the space for the employee name and keep a separate confidential list of the case numbers and names. Please see regulations for additional details.

California OSHA 300 Series forms may be downloaded at:
http://www.dir.ca.gov/dosh/PubOrder.asp
Cal/OSHA Form 300 (Rev. 7/2007)
Log of Work-Related Injuries and Illnesses

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 CCR Title 8 Section 14300.8 through 14300.12. Feel free to use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (Cal/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 Cal/OSHA office for help.

<table>
<thead>
<tr>
<th>Case #</th>
<th>Employee’s Name</th>
<th>Job Title (e.g. welder)</th>
<th>Date of injury or onset of illness (month/day)</th>
<th>Where the event occurred (e.g. Loading dock north end)</th>
<th>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)</th>
</tr>
</thead>
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<tr>
<td>1</td>
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<td>15</td>
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</tbody>
</table>

NOTE: If additional pages are required, copy Page Totals to the top (row 15) of the next page.

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 programs. See CCR Title 8 14300.29(b)(6)-(10).

Page Totals

<table>
<thead>
<tr>
<th>Injury</th>
<th>Skin Disorder</th>
<th>Respiratory Condition</th>
<th>Poisoning</th>
<th>Hearing Loss</th>
<th>All Other Illnesses</th>
<th>Total Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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

Page 1 of 1
OSHA’s Form 300A:

*Summary of Work-Related Injuries and Illnesses*
OSHA’s Form 300A (Rev. 01/2004)

Summary of Work-Related Injuries and Illnesses

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>
<thead>
<tr>
<th>Category</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of deaths</td>
<td></td>
</tr>
<tr>
<td>Total number of cases with days away from work</td>
<td></td>
</tr>
<tr>
<td>Total number of cases with job transfer or restriction</td>
<td></td>
</tr>
<tr>
<td>Total number of other recordable cases</td>
<td></td>
</tr>
</tbody>
</table>

**Number of Days**

<table>
<thead>
<tr>
<th>Category</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of days away from work</td>
<td></td>
</tr>
<tr>
<td>Total number of days of job transfer or restriction</td>
<td></td>
</tr>
</tbody>
</table>

**Injury and Illness Types**

<table>
<thead>
<tr>
<th>Type</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Injuries</td>
<td></td>
</tr>
<tr>
<td>(2) Skin disorders</td>
<td></td>
</tr>
<tr>
<td>(3) Respiratory conditions</td>
<td></td>
</tr>
<tr>
<td>(4) Poisonings</td>
<td></td>
</tr>
<tr>
<td>(5) Hearing loss</td>
<td></td>
</tr>
<tr>
<td>(6) All other illnesses</td>
<td></td>
</tr>
</tbody>
</table>

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 aspect 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**

- Year 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**

- Annual average number of employees ____________________________
- Total hours worked by all employees last year ____________________________

**Sign Here**

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

<table>
<thead>
<tr>
<th>Company executive</th>
<th>Title</th>
<th>Phone</th>
<th>Date</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Cal/OSHA's Form 300A:

Summary of Work-Related Injuries and Illnesses

California OSHA 300 Series forms may be downloaded at:
http://www.dir.ca.gov/dosh/PubOrder.asp
Cal/OSHA Form 300A (Rev. 7/2007)
Summary of Work-Related Injuries and Illnesses

All establishments covered by CCR Title 8 Section 14300 must complete this Annual Summary, 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 Cal/OSHA Form 300 in its entirety. They also have limited access to the Cal/OSHA Form 301 or its equivalent. See CCR Title 8 Section 14300.35, in Cal/OSHA’s recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases

<table>
<thead>
<tr>
<th>Total number of deaths</th>
<th>Total number of cases with days away from work</th>
<th>Total number of cases with job transfer or restriction</th>
<th>Total number of other recordable cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>(G)</td>
<td>(H)</td>
<td>(I)</td>
<td>(J)</td>
</tr>
</tbody>
</table>

Number of Days

<table>
<thead>
<tr>
<th>Total number of days away from work</th>
<th>Total number of days of job transfer or restriction</th>
</tr>
</thead>
<tbody>
<tr>
<td>(K)</td>
<td>(L)</td>
</tr>
</tbody>
</table>

Injury and Illness Types

<table>
<thead>
<tr>
<th>Total number of…</th>
<th>(M)</th>
<th>(4) Poisonings</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Injuries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Skin Disorders</td>
<td></td>
<td>(5) Hearing loss</td>
</tr>
<tr>
<td>(3) Respiratory Conditions</td>
<td></td>
<td>(6) All other illnesses</td>
</tr>
</tbody>
</table>

Facility Information

<table>
<thead>
<tr>
<th>Establishment name:</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Industry description:</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Standard Industrial Classification (SIC)

If known (e.g., SIC 3715) 

Employment Information

(If you don’t have these figures, use the optional Worksheet to estimate)

<table>
<thead>
<tr>
<th>Annual average number of employees</th>
<th>Total hours worked by all employees last year</th>
</tr>
</thead>
</table>

Sign here

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's Form 301:

*Injury and Illness Incident Report*
OSHA’s Form 301
Injury and Illness Incident Report

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.

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
_____/_____ AM/PM
13) Time of event ☐ 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.
Cal/OSHA’s Form 301:

Injury and Illness Incident Report

California OSHA 300 Series forms may be downloaded at:
http://www.dir.ca.gov/dosh/PubOrder.asp
Cal/OSHA Form 301
Injury and Illness Incident Report

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 Cal/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 instructions and information asked for on this form.

According to CCR Title 8 Section 14300.33 Cal/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.

Information about the employee

1) Full Name ____________________________ 10) Case number from the Log ____________ (Transfer the case number from the Log after you record the case.)

2) Street ________________________________
   City __________ State ______ Zip ________

3) Date of birth ________________ 11) Date of injury or illness ___________

4) Date hired ____________________________ 12) Time employee began work AM/PM

5) Male ☐ Female ☐

Information about the physician or other healthcare professional

6) Name of physician or other healthcare 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 spayed 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 _______ / _______ / _______
California Only Training in Aerosol Transmissible Diseases Screening Protocol Sign-In Sheet

For: Aerosol Transmissible Diseases Screening Protocol

Our ATD Screening Protocol has been reviewed by:

<table>
<thead>
<tr>
<th>Reviewer’s Name (print)</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>_______________________</td>
<td></td>
</tr>
</tbody>
</table>

Signature of Reviewer

<table>
<thead>
<tr>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>_____</td>
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</tbody>
</table>

Sign below to indicate that you have read and received training in your facility’s ATD Screening Protocol and that you have been given the opportunity to ask questions to management to ensure a complete understanding of the screening protocol:

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Maintain a copy of this form for a period of three years.
**Annual BBP Training Record**

**Facility Name**
Complete this attendance sheet prior to beginning the required Annual Bloodborne Pathogens Training Review. All employees with the potential for exposure to bloodborne pathogens must be in attendance, if possible. Keep completed sheet for recordkeeping. This record should be retained for a minimum of three years. This training covers the 14 elements of the Bloodborne Pathogens Standard. If additional rows are needed, attach separate sheet.

<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>Person or Position Conducting Training</th>
</tr>
</thead>
</table>

Qualification

**EMPLOYEES IN ATTENDANCE**

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Signature</th>
<th>Job Title</th>
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</tbody>
</table>

Signature of Person Conducting Meeting  Title  Date
**Employee Exposure Determination**

The following is a list of all our job classifications in which employees have occupational exposure to bloodborne pathogens.

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Department/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Phlebotomists</td>
<td>Clinical Lab</td>
</tr>
</tbody>
</table>

The following is a list of job classifications in which employees may have potential exposure to bloodborne pathogens on an occasional or intermittent basis as a result of performing the specific tasks itemized below.

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Department/Location</th>
<th>Task/Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Housekeeper</td>
<td>Environmental Services</td>
<td>Handling regulated waste</td>
</tr>
</tbody>
</table>

Part-time, temporary, contract and per diem employees are covered by the Bloodborne Pathogens Standard.

Those employees who are determined to have occupational exposure to blood or other potentially infectious materials (OPIM) must comply with the procedures and work practices outlined in this facility’s ECP.
Exposure Control Plan (ECP) Annual Documentation Form

1. This is to document the fact that I have, on the indicated date, performed the required annual review and update as necessary for the Bloodborne Pathogens Exposure Control Plan of our facility.

<table>
<thead>
<tr>
<th>Documenter's Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

2. This is to document the fact that our facility has evaluated and implemented safer medical devices on an ongoing basis during the past year. These evaluations were conducted by means of (check all that apply):

- Attendance at commercial exhibits of vendors of such devices at professional meetings
- Examination of products presented by device vendors calling on our facility
- Monitoring professional journals and literature on a regular basis
- Reports from colleagues
- Recommendations from employees
- Staff evaluation of selected products. Device Evaluation Forms (see sample) are to be utilized for such evaluations and are to be maintained and made available upon request.

<table>
<thead>
<tr>
<th>Documenter's Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

3. This is to document the fact that solicitation of non-managerial input into the evaluation of safer medical devices, as well as into any other area of our operations relating to employee safety, has been conducted. A Solicitation of Input of Non-Managerial Employees form (see sample) is to be utilized for further documentation of such solicitation and is to be maintained and made available upon request.

<table>
<thead>
<tr>
<th>Documenter's Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
Solicitation of Input of Non-Managerial Employees

Documenter’s Name | Signature | Date
--- | --- | ---

It is the policy of our facility that our non-managerial employees who provide direct patient care and are potentially exposed to injuries from contaminated sharps shall be involved in providing input for the identification, evaluation, and selection of safer medical devices and for effective engineering and work practice controls. The input of our employees is requested and required as a vital part of our commitment to providing a safe and healthful workplace.

Sign below to document that, on this date, your input into the selection of safer medical devices and into any other workplace safety related matters or concerns about our facility, our engineering controls, personal protective equipment, or about our work practices, has been duly solicited. Please also feel free to bring any other issues concerning such matters to our management’s attention on an ongoing basis.

Name | Signature | Job Title
--- | --- | ---

Name | Signature | Job Title
--- | --- | ---

Name | Signature | Job Title
--- | --- | ---

Name | Signature | Job Title
--- | --- | ---

Name | Signature | Job Title
--- | --- | ---

Name | Signature | Job Title
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Name | Signature | Job Title
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Name | Signature | Job Title
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Name | Signature | Job Title
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Name | Signature | Job Title
--- | --- | ---

Name | Signature | Job Title
--- | --- | ---
# Evaluation Form for Safety Needle/Syringe Devices

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Department/Unit</th>
<th>Date</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Name/ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

## Evaluation Issues

1. The device functioned satisfactorily for its intended purpose  
   - [ ] Yes  
   - [ ] No  
   - [ ] Unknown/Not Applicable

2. Device is suitable for most standard syringe functions  
   - [ ] Yes  
   - [ ] No  
   - [ ] Unknown/Not Applicable

3. The product is available in the sizes needed  
   - [ ] Yes  
   - [ ] No  
   - [ ] Unknown/Not Applicable

4. The product is simple to operate  
   - [ ] Yes  
   - [ ] No  
   - [ ] Unknown/Not Applicable

5. The use of this product requires no training  
   - [ ] Yes  
   - [ ] No  
   - [ ] Unknown/Not Applicable

6. The safety feature activated with a one-handed technique  
   - [ ] Yes  
   - [ ] No  
   - [ ] Unknown/Not Applicable

7. The safety feature worked reliably  
   - [ ] Yes  
   - [ ] No  
   - [ ] Unknown/Not Applicable

8. Both hands remain protected during engagement of safety feature  
   - [ ] Yes  
   - [ ] No  
   - [ ] Unknown/Not Applicable

9. The safety feature does not interfere with normal use of this product  
   - [ ] Yes  
   - [ ] No  
   - [ ] Unknown/Not Applicable

10. The product is equally satisfactory for different or diverse patient populations (adults, children, heavy, thin, etc)  
    - [ ] Yes  
    - [ ] No  
    - [ ] Unknown/Not Applicable

11. The safety feature could not be bypassed  
    - [ ] Yes  
    - [ ] No  
    - [ ] Unknown/Not Applicable

12. The safety feature works well with a wide variety of hand sizes  
    - [ ] Yes  
    - [ ] No  
    - [ ] Unknown/Not Applicable

13. The device is no more difficult to process after use than non-safety devices  
    - [ ] Yes  
    - [ ] No  
    - [ ] Unknown/Not Applicable

## Further Input

14. Did you experience any injuries with the test device?  
    - [ ] Yes  
    - [ ] No

15. About how many times did you use the test device before you were comfortable using it? __________________

16. Did you have any problems with this device?  
    - [ ] Yes  
    - [ ] No (if yes, please explain)  
    ____________________________________________________________
    ____________________________________________________________

17. Which device would you rather use? (Please check one)  
    - [ ] The product we normally use  
    - [ ] This test product  
    - [ ] Other ____________________________

18. Comments:  
    ____________________________________________________________
    ____________________________________________________________
Workplace Hazard Assessment

OSHA requires employers to assess the work environment to determine if hazards are present which necessitate the use of Personal Protective Equipment, PPE. When PPE is needed to protect employees from hazards, we are required to specify the correct PPE and its usage.

To accomplish this,

is our PPE coordinator and will ensure that the following requirements are met.

- A hazard assessment is accomplished to identify hazards.
- The appropriate PPE is assigned to the potential hazard.
- PPE is provided.
- Properly fitted PPE is maintained and available.
- Employees are trained on PPE usage: how to use it, when it is required, and what are its limitations.
- PPE selection decisions and criteria will be communicated to employees.
- The employer must also certify that the workplace hazard assessment and PPE selection has been performed.

PPE Selection and Certification Form

<table>
<thead>
<tr>
<th>Task</th>
<th>Hazard</th>
<th>PPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: stripping porcelain from dental casting</td>
<td>hydrofluoric acid</td>
<td>utility gloves, eye shield, face shield as needed</td>
</tr>
</tbody>
</table>

This is to certify that I have performed an assessment of our workplace and procedures, and that the hazards found are listed above along with the PPE to be used.

Name: ____________________  Signature: ____________________  Date: ______________
Personal Protective Equipment

Based on our hazard assessments, the types of PPE selected and made available to our employees are as follows (check all that apply):

**Gloves**
- Latex Exam (powdered or powder-free) circle one or both if used
- Vinyl Exam
- Sterile Surgical
- Utility gloves
  - Nitrile
  - Neoprene
- ___________________
- ___________________

**Respiratory Protection**
- N95 respirators
- Other respirators
  - ___________________
  - ___________________

**Eye and Face Protection**
- Safety Glasses with sideshields
- Splash goggles
- Face Shield
- Face Masks
  - ___________________
  - ___________________

**Hearing Protection**
- Ear Plugs
- Ear Muffs
  - ___________________
  - ___________________

**Protective Clothing**
- Lab Coats
- Gowns
- Smocks
- Bouffants
- Booties

Helpful Internet Links to more information can be found in the RESOURCE GUIDE section.

Keep in mind that whenever respirator use is required, it also triggers implementation of the provisions of the Respiratory Protection Standard (see SUPPLEMENTARY WORKPLACE CONCERNS section of this manual for further information).
Certification of PPE Training

The affected employees listed below have been trained on the PPE selected for this facility as the result of our Workplace Hazard Assessment.

Items of PPE for which training has been provided:

___________________ ____________________ ___________________ ___________________
___________________ ____________________ ___________________ ___________________
___________________ ____________________ ___________________ ___________________
___________________ ____________________ ___________________ ___________________
___________________ ____________________ ___________________ ___________________

Employees trained on the above items of PPE:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date(s) of Training</th>
<th>PPE Item for which Training was Provided (If different from items already listed above)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

This is to certify that the employees listed above have been trained on the PPE indicated above and that they understand when that PPE is necessary, what PPE is necessary, how to properly don (put on), off (remove), adjust, and wear the PPE, the limitations of the PPE, and the proper care, maintenance, useful life, and disposal of the PPE.

Printed Name       Signature       Date

Helpful Internet Links to more information can be found in the RESOURCE GUIDE section.
<table>
<thead>
<tr>
<th>Item, Type of Surface</th>
<th>Cleaner, Disinfectant, or Sterilant to Be Used</th>
<th>Frequency of Cleaning</th>
<th>PPE, Engineering Controls to Be Used</th>
<th>Employees Assigned Task</th>
<th>Location Within Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example:</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Equipment (list items)</td>
<td>Protective coverings, plastic wrap, aluminum foil, imperviously-backed absorbent paper used to cover equipment and environmental surfaces</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Contaminated work surfaces (specify)</td>
<td>Bins, pails, cans, similar receptacles</td>
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</tr>
<tr>
<td>Broken glassware</td>
<td>Reusable sharps, hand instruments, etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Hepatitis B Vaccination Declination Form

This declination form should be completed and placed in the employee’s medical file.

The employer shall assure that employees who decline to accept hepatitis B vaccination offered by the employer sign the following statement as required by the Bloodborne Pathogens Standard.

I understand that due to my occupational exposure to blood or OPIM I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine at no charge to myself, however, I declined this vaccine at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or OPIM and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

________________________________________________________________________
Employee Name

________________________________________________________________________
Employee Signature Date

________________________________________________________________________
Identification Number (if applicable) Date of Birth

________________________________________________________________________
Employer or OSHA Coordinator

________________________________________________________________________
Employer Date

Helpful Internet Links to more information can be found in the RESOURCE GUIDE section.
Letter of Receipt

I have received or already have a copy of the Bloodborne Pathogens Standard.

__________________________________________   ________________________
Healthcare Provider                        Date
# BBP Exposure Incident Report Form

This report must be completely filled out after any employee exposure incident. A copy of this report should be provided to the licensed healthcare professional providing post-exposure evaluation and treatment to the injured employee. This report is to be placed in the employee’s medical records and must remain confidential.

## Exposed Employee

<table>
<thead>
<tr>
<th>Name</th>
<th>Identification Number</th>
</tr>
</thead>
</table>

| Date of Incident   | Type of Incident      |

Employee’s duties as they relate to the incident:

Description of exposure routes and circumstances under which incident occurred:

Check appropriate responses below:

- [ ] Yes  [ ] No  Exposed employee has been counseled as to applicable laws and regulations concerning disclosure of the identity and infectious status of the source patient.

- [ ] Yes  [ ] No  Exposed employee has legally consented to blood testing.

- [ ] Yes  [ ] No  Exposed employee has agreed to have baseline blood collection, but doesn’t give consent at this time for HIV serologic testing and understands that the sample shall be preserved for 90 days in case employee decides to complete testing.

## Medical Attention

The exposed employee was referred to the following physician or other licensed healthcare professional for medical evaluation, counseling, and follow-up:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
</tr>
</thead>
</table>

| Address            |                  |

| Date of Exam       | Date of Follow-up|

Exposed employee’s vaccination records were made available to the attending physician or licensed healthcare professional on:

A copy of the Bloodborne Pathogens Standard was delivered to the attending physician or other licensed healthcare professional on:

A copy of the physician or other licensed healthcare professional’s written opinion was delivered to the employee on:
Source Patient

Name

Address

City

State

Zip Code

Check appropriate responses below:

☒ Yes ☐ No  Source patient has legally consented to have his/her blood tested for HIV and HBV infectivity.

☒ Yes ☐ No  The legally required consent cannot be obtained.

Reason

☒ Yes ☐ No  Source patient is known to be infected with HBV.

☒ Yes ☐ No  Source patient is known to be infected with HIV.

☒ Yes ☐ No  Results of source patient’s tests have been provided to the exposed employee.

Recordkeeping

The following items will be maintained IN STRICT CONFIDENTIALITY and not disclosed without the employee’s written consent to anyone within or outside the workplace.

Records must be kept for duration of employment plus 30 (thirty) years.

1. The employee Exposure Incident Form.

2. A record of the employee’s hepatitis B vaccination status including the dates of all vaccinations and any medical records relative to the employee’s ability to receive vaccination.

3. A copy of all results of examinations, medical testing, and follow-up procedures.

4. The employer’s copy of all results of the Healthcare professional’s written opinion.

5. Identity of source patient and source patient’s blood test results.

Form completed by:

Name

Title

Exposed Employee Signature

Date

Employer Signature

Date
BBP Exposure Incident Report Form
Healthcare Professional’s Written Opinion

Exposed Employee

<table>
<thead>
<tr>
<th>Name</th>
<th>Identification Number</th>
</tr>
</thead>
</table>

| Date of Incident  | Type of Incident      |

To the Evaluating Healthcare Professional: After you have determined whether there are contraindications to vaccination of this employee with hepatitis B vaccine, please state in the space below only if vaccine was indicated and if vaccine was received. Following completion of this form, please provide the original to the employee and a copy to the employer.

1. ____________ Vaccine was indicated.
2. ____________ Vaccine was provided.

After your evaluation of this employee, please assure that the following information has been furnished to the employee and provide your initials beside the following statements:

1. ____________ The employee has been informed of the results of this evaluation.
2. ____________ The employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials, which require further evaluation and treatment.

All other findings or diagnoses shall remain confidential and shall not be included in the written report.

_______________________________________________________
Healthcare Professional’s Signature

_______________________________________________________  ______________
Healthcare Professional’s Name (printed)    Date

Medical Attention
The exposed employee was referred to the following physician or other licensed healthcare professional for medical evaluation, counseling, and follow-up:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

Date of Exam        Date of Follow-up
Sharps Injury Log

Please complete a Log for each employee exposure incident involving a sharp. Check the box corresponding to the most appropriate answer. Please print

<table>
<thead>
<tr>
<th>Injury ID (please leave blank)</th>
<th>Facility ID (please leave blank)</th>
</tr>
</thead>
</table>

Institution | Department |

Address | Page # Of |

City | State | Zip Code |

Date filled out | By | Phone |

Facility Injury ID# | Date of Injury | Time of Injury | Sex (optional) |

Description of the exposure incident:

<table>
<thead>
<tr>
<th>Job Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
</tr>
<tr>
<td>DA</td>
</tr>
<tr>
<td>RDH</td>
</tr>
<tr>
<td>Housekeeper/Laundry</td>
</tr>
<tr>
<td>CNA/HHA</td>
</tr>
<tr>
<td>Nurse</td>
</tr>
<tr>
<td>RDA</td>
</tr>
<tr>
<td>Student, type</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Department/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Room</td>
</tr>
<tr>
<td>Operating Room</td>
</tr>
<tr>
<td>CCU/ICU</td>
</tr>
<tr>
<td>Clinical Laboratory</td>
</tr>
<tr>
<td>Medical/Outpatient Clinic</td>
</tr>
<tr>
<td>Emergency</td>
</tr>
<tr>
<td>Procedure Room</td>
</tr>
<tr>
<td>Home</td>
</tr>
<tr>
<td>Service/Utility Area (disp. rm./laundry)</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draw Venous Blood</td>
</tr>
<tr>
<td>Draw Arterial Blood</td>
</tr>
<tr>
<td>Injection, through skin</td>
</tr>
<tr>
<td>Start IV/Set-Up Heparin Lock</td>
</tr>
<tr>
<td>Unknown/Not Applicable</td>
</tr>
<tr>
<td>Heparin/Saline Flush</td>
</tr>
<tr>
<td>Cutting</td>
</tr>
<tr>
<td>Suturing</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>
Did the Exposure Incident Occur

- During use of sharp
- While putting sharp into disposable container
- Between steps of a multi-step procedure
- Sharp left in inappropriate place (table, bed, etc.)
- After use and before disposal of sharp
- Other ______________________

Body Part

- Finger
- Hand
- Arm
- Face/Head
- Torso
- Leg
- Other ______________________

Identify Sharp involved (if known)

Type ______________________ Brand ______________________ Model ______________________

e.g. 18g needle/ABC Medical/"no stick" syringe

Did the device being used have engineered sharps injury protection?  □ Yes □ No □ Don’t Know

Was the protective mechanism activated?  □ Yes-Fully □ Yes-Partially □ No

Did the exposure incident occur: □ Before □ During □ After Activation

Exposed Employee

If sharp had no engineered sharps injury protection, do you have an opinion that such a mechanism could have prevented the injury?  □ Yes □ No

Explain

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Exposed Employee

Do you have an opinion that any other engineering, administrative, or work practice control could have prevented the injury?  □ Yes □ No

Explain

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Hazardous Chemical Inventory Master List

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
<th>Phone</th>
</tr>
</thead>
</table>

is responsible for this list of hazardous chemicals and related work practices used at this location and will update the list as necessary.

Following is the master list of these hazardous chemicals. Our list of chemicals identifies all of the chemicals used in our work process.

Each list also identifies the corresponding MSDS. Use additional sheets if needed.

Many facilities like to store each MSDS in a notebook and assign a simple numerical sequence numbering system to them for ease of location between the master list and the position of the MSDS in the notebook. This is simply a number you assign; it is not an “official” number that you must look for.

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Location of Use/Storage</th>
<th>MSDS Name/Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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</tbody>
</table>
Workplace Hazard Assessment

OSHA requires employers to assess the work environment to determine if hazards are present which necessitate the use of Personal Protective Equipment, PPE. When PPE is needed to protect employees from hazards, we are required to specify the correct PPE and its usage.

To accomplish this,

Name Location Phone

is our PPE coordinator and will ensure that the following requirements are met.

- A hazard assessment is accomplished to identify hazards.
- The appropriate PPE is assigned to the potential hazard.
- PPE is provided.
- Properly fitted PPE is maintained and available.
- Employees are trained on PPE usage: how to use it, when it is required, and what are its limitations.
- PPE selection decisions and criteria will be communicated to employees.
- The employer must also certify that the workplace hazard assessment and PPE selection has been performed.

PPE Selection and Certification Form

<table>
<thead>
<tr>
<th>Task</th>
<th>Hazard</th>
<th>PPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: stripping porcelain from dental casting</td>
<td>hydrofluoric acid</td>
<td>utility gloves, eye shield, face shield as needed</td>
</tr>
</tbody>
</table>

This is to certify that I have performed an assessment of our workplace tasks and procedures, and that the hazards found are listed above along with the PPE to be used.

Name Signature Date
Personal Protective Equipment

Based on our hazard assessments, the types of PPE selected and made available to our employees are as follows (check all that apply):

**Gloves**
- Latex Exam (powdered or powder-free) circle one or both if used
- Vinyl Exam
- Sterile Surgical
- Utility gloves
  - Nitrile
  - Neoprene
- ______________
- ______________

**Respiratory Protection**
- N95 respirators
- Other respirators
  - ______________
  - ______________

**Eye and Face Protection**
- Safety Glasses with sideshields
- Splash goggles
- Face Shield
- Face Masks
  - ______________
  - ______________

**Hearing Protection**
- Ear Plugs
- Ear Muffs
  - ______________
  - ______________

**Protective Clothing**
- Lab Coats
- Gowns
- Smocks
- Bouffants
- Booties

Helpful Internet Links to more information can be found in the RESOURCE GUIDE section.

Keep in mind that whenever respirator use is required, it also triggers implementation of the provisions of the Respiratory Protection Standard (see SUPPLEMENTARY WORKPLACE CONCERNS section of this manual for further information).
Certification of PPE Training

The affected employees listed below have been trained on the PPE selected for this facility as the result of our Workplace Hazard Assessment.

Items of PPE for which training has been provided:

_________________________ _______________________ _____________________ ______________________
_________________________ _______________________ _____________________ ______________________
_________________________ _______________________ _____________________ ______________________
_________________________ _______________________ _____________________ ______________________
_________________________ _______________________ _____________________ ______________________
_________________________ _______________________ _____________________ ______________________
_________________________ _______________________ _____________________ ______________________
_________________________ _______________________ _____________________ ______________________

Employees trained on the above items of PPE:

Name                        Date(s) of Training                        PPE Item for which Training was Provided
_________________________                        ______________________________                        ______________________________
_________________________                        ______________________________                        ______________________________
_________________________                        ______________________________                        ______________________________
_________________________                        ______________________________                        ______________________________
_________________________                        ______________________________                        ______________________________
_________________________                        ______________________________                        ______________________________
_________________________                        ______________________________                        ______________________________
_________________________                        ______________________________                        ______________________________

This is to certify that the employees listed above have been trained on the PPE indicated above and that they understand when that PPE is necessary, what PPE is necessary, how to properly don (put on), doff (remove), adjust, and wear the PPE, the limitations of the PPE, and the proper care, maintenance, useful life, and disposal of the PPE.

Printed Name                        Signature                        Date
Hazardous Chemicals Inventory Log / Table of Contents -

This is a worksheet to inventory the hazardous chemicals found in our facility. Please check the appropriate box for each material found in our facility. Upon completion of your hazardous material inventory, fill out MSDS Request Form(s) for the materials that do not have a corresponding MSDS or search with SteriSafe™ MSDS if available.

<table>
<thead>
<tr>
<th>Hazardous Chemicals</th>
<th>Description Of Materials</th>
<th>Have MSDS</th>
<th>Need MSDS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
# Weekly Eye Wash Station Inspection Checklist & Log

<table>
<thead>
<tr>
<th>Location</th>
<th>Date</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluation Issues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Free from obstruction</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>2. Accessible within 10 seconds</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>3. Easily activated</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>4. Outlets capped</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>5. Water flowing from both eyepieces</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>6. Flow of water is of equal height</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>7. Water is clear</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>8. Temperature controlled at tepid level</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
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</tr>
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<td>Location</td>
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<td>Initials</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------</td>
<td>----------</td>
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<td></td>
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<td>❑ No</td>
</tr>
<tr>
<td>7. Water is clear</td>
<td>❑ Yes</td>
<td>❑ No</td>
</tr>
<tr>
<td>8. Temperature controlled at tepid level</td>
<td>❑ Yes</td>
<td>❑ No</td>
</tr>
</tbody>
</table>
Request for Manufacturer’s Material Safety Data Sheets (MSDS)

Date

TO

Manufacturer

Address

City State Zip Code

Phone Fax

FROM

Name of Facility

Address

City State Zip Code

Phone Fax

To Whom it May Concern

Please send us a Material Safety Data Sheet (MSDS) on your product(s) named:

Name of Product(s)

Product Number(s) or Code(s)

Please forward the MSDS to our facility as soon as possible:

Attention Title

Signature

Thank you for your cooperation.
Emergency Action Plan

Establish procedures and train employees on when and how to sound an alarm and notify emergency personnel. In addition, you must designate and train employees to assist in a safe and orderly evacuation of other employees. You must also review the Emergency Action Plan with each employee covered when the following occur:

- When the plan is developed or an employee is assigned initially to a job
- When an employee’s responsibilities under the plan change
- When the plan is changed

How will fires and other emergencies be reported?

In an emergency, how will employees be informed?

In an emergency, our evacuation will be ( ) full or ( ) partial?

We will evacuate through the following primary and alternate exit routes:

Primary evacuation route:

Alternate evacuation route:

Which employee(s), if any, will stay behind and perform critical plant operations?

We will evacuate to the following safe location:

Primary safe location:

Alternate safe location:

How will every employee be accounted for?

Which employee(s), if any, may perform rescue or medical duties?

How frequently will drills be performed for the above procedures?

Who is your contact person for communicating with fire, police, media, etc?

What is the name or job title of the individual for employee(s) to contact for detailed plan information?

This Emergency Action Plan’s Policy for Portable Fire Extinguisher use by our employees is found in the following Fire Prevention Plan.
Fire Prevention Plan

When you assign employees to a job, you must inform them of any fire hazards they may be exposed to. You must also review with each employee those parts of the fire prevention plan necessary for self-protection.

---

What are the major fire hazards in our workplace?
List any fire hazards such as flammable or combustible liquids, gases, etc. If no special hazards are present, write “No special hazards use present; general office materials only” or other suitably descriptive information.

---

What are the proper handling and storage procedures for hazardous materials in our workplace?
If no hazardous materials requiring proper handling and storage procedures are present, write “Does not apply-no hazardous materials present.”

---

What potential ignition sources exist, and how are they controlled?
If no potential ignition sources exist, write “No potential ignition sources exist.”

---

What type of fire protection equipment is available to control each major hazard?
List any fire protection equipment such as portable fire extinguishers, sprinkler system, etc., that are available. If none is available, write “No fire protection equipment available.”

---

What are the procedures to control accumulations of flammable and combustible waste materials?
If no heat producing equipment is present, write “No heat producing equipment present.”

---

What are the procedures for regular maintenance of safeguards installed on heat-producing equipment to prevent the accidental ignition of combustible materials?

---

What is the name or job title of the individual responsible for maintaining equipment to prevent or control sources of ignition or fires?

---

What is the name or job title of employee(s) responsible for the control of fuel source hazards?
If no fuel source hazards are present, write “No fuel source hazards present.”

---

The policy of this Fire Prevention Plan concerning portable fire extinguisher use by our employees follows.
# Electrical Audit Check List

Facility Location: ____________________________ Date: ________________

Person Conducting the Audit: ____________________________

<table>
<thead>
<tr>
<th>Audit Item</th>
<th>In Compliance (Y/N)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Electrical Service Panels</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All disconnecting switches and circuit breakers labeled</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>Is there at least 36” free space in front of all electrical panels</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>All circuit breaker panel doors kept closed</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>Other _________________________________________</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td><strong>Electrical Outlets/Switches</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All electrical enclosures (switches, receptacles, junction boxes) provided with intact and tight covers</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>Other _________________________________________</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td><strong>Overloaded Circuits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circuits and cords are not overloaded</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>Other _________________________________________</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td><strong>Flexible Extension Cords</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extension cords have three-prong plugs for grounding</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>Flexible cords not spliced</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>All cords and wiring free of fraying</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>Flexible cords not run through doors, windows, or wall openings</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>Machines designed for fixed location serviced by permanent wiring</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>Other _________________________________________</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td><strong>Damp/Wet Locations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All outlets near water sources protected by a GFCI</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>Other _________________________________________</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td><strong>Guarding Live Parts</strong></td>
<td></td>
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</tr>
<tr>
<td>No exposed electrical conductors or parts</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>Other _________________________________________</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td><strong>Machine Disconnects</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power shut off switch in sight of its motor device</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>Other _________________________________________</td>
<td>❑ Yes ❑ No</td>
<td></td>
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<tr>
<td><strong>Grounding</strong></td>
<td></td>
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<tr>
<td>Portable electrical tools grounded or double insulated</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>Electrical appliances and machinery/equipment grounded</td>
<td>❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td>Other _________________________________________</td>
<td>❑ Yes ❑ No</td>
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</tbody>
</table>
Lockout/Tagout Procedure

Lockout/Tagout Procedure for ___________________________________________________

The following procedure is to be followed by any person(s) performing maintenance or servicing operations on this particular piece of machinery in accordance with our lockout/tagout procedures.

❏ Electrical: The following electrical lockout/tagout steps are to be conducted:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

❏ Pneumatic: The following pneumatic lockout/tagout steps are to be conducted:

________________________________________________________________________
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❏ Mechanical: The following mechanical lockout/tagout steps are to be conducted:

________________________________________________________________________
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❏ Hydraulic: The following hydraulic lockout/tagout steps are to be conducted:

________________________________________________________________________
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________________________________________________________________________

Equipment is now locked out.

Please see back side for Procedure for Returning Equipment/Machine to Service.
Procedure for Returning Equipment/Machine to Service:

After servicing and/or maintenance is complete and the equipment is ready for normal operations, check the area around the machine or equipment to ensure that no one is exposed. After all tools have been removed from the machine or equipment, guards have been reinstalled, and all employees are in the clear, remove all lockout or tagout devices. Operate the energy isolating devices to restore energy.

☐ Overall Hazards:

_______________________________________________________
_______________________________________________________
_______________________________________________________
_______________________________________________________
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_______________________________________________________
Lockout/Tagout Audit Checklist and Certification

Periodic Inspection - Review of Lockout/Tagout Program
General - a periodic review of the lockout/tagout program must be conducted by the LOTO Coordinator. This review will be conducted on an annual basis. The review/inspection will consist of observing a lockout procedure and discussing the procedure and responsibilities with the observed employee.

The following form is to be used to document all reviews/inspections:

Date: ________________________
Person Performing Review: ________________________________________
Machine or Equipment: ____________________________________________
Authorized Employee Observed: _____________________________________

1. The reviewer reviewed with the authorized employee the employee’s responsibilities and knowledge of the lockout procedure and found no deficiencies. _________________ (Initial)

2. The reviewer reviewed with the authorized and affected employees each employee’s responsibilities and the limitations of tags and found no deficiencies. ______________ (Initial)

If the reviewer found deficiencies requiring correction and retraining, they are noted below:

_______________________________________________________________________________________
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Certification of Reviewer: __________________________
# Lockout/Tagout Training Record

**Facility Name**

Complete this attendance sheet prior to your lockout/tagout training. All authorized and affected employees must be in attendance, if possible. Keep completed sheet for recordkeeping. This record should be retained for a minimum of three years. Attach separate sheet if additional names are needed.

<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>Subject(s) Discussed</th>
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<tbody>
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</table>

**Person or Position Conducting Meeting**

**Employees in Attendance**

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Signature</th>
<th>Title</th>
<th>Authorized</th>
<th>Affected</th>
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</thead>
<tbody>
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**Signature of Person Conducting Meeting**

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<th>Date</th>
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</table>
# Voluntary and Required Respirator Use Hazard Evaluation

<table>
<thead>
<tr>
<th>Task/Operation</th>
<th>Type Of Respirator</th>
<th>Required</th>
<th>Voluntary</th>
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<tbody>
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</table>
## Hazard Evaluation

<table>
<thead>
<tr>
<th>Department</th>
<th>Work Process</th>
<th>Hazardous Substance</th>
<th>Monitor Results (Over 8 Hrs)</th>
<th>Respiratory Equipment</th>
</tr>
</thead>
<tbody>
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</table>
# Respirator Fit Testing Record

Employees fit tested

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Type Of Respirator</th>
<th>Model</th>
<th>Size</th>
<th>Fit Tested By</th>
<th>Date</th>
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</table>

Instructor | Signature | Date
Respiratory Training Written/Oral Test

Ensure that each employee can demonstrate knowledge of at least the following.

1. Explain where and why we use respirators.

2. How can improper fit affect your protection?

3. Explain the limitations of your respirator.

4. Explain how to clean, inspect, and store your respirator.

Demonstration of understanding the necessary information may be done with either a written or an oral test using the criteria above.

Employees in Attendance

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date</th>
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</table>

Instructor

<table>
<thead>
<tr>
<th>Instructor</th>
<th>Signature</th>
<th>Date</th>
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<tbody>
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</table>
Resident/Patient Handling Assessment Checklist

Which of the following activities do you perform and which have been involved in past injuries?

Transfers to and from:

- Bed
- Other beds
- Chairs
- Gurneys
- Floor
- Walker
- Toilet/bedside commode
- Bathtub
- Wheelchairs
- Showers

Notes:

Ambulating, Repositioning, Manipulating

- Repositioning/turning/holding
- Hand cranking beds
- Assisting with ambulation

Notes:

Transporting or Moving Equipment

- Beds or gurneys
- Wheelchairs
- Room furniture
- Carts
- Monitors or equipment

Notes:

Performing Activities of Daily Living

- Bathing in bed or bathtub, showering
- Performing personal hygiene
- Dressing and undressing
- Making beds with residents/patients in them
- Toileting

Notes:
Accident/Incident Report Form (for injuries other than sharps related)

Date of incident:  

Time:  

AM/PM

Please check one, who was injured?  

❏ Employee  

❏ Patient  

❏ Visitor

Name of injured person:

Address:

Phone Number(s):

Date of birth:  

❏ Male  

❏ Female

Type of injury:

Location of occurrence:

Details of incident:

Injury requires physician/hospital visit?  

❏ Yes  

❏ No

Name of physician/hospital:

Address:

City, State, Zip

Physician/hospital phone number:

Physician notes, if any

Signature of injured party  

Date

Witness Signature  

Date

Please indicate if no medical attention was desired (signature required)  

❏ Yes  

❏ No

Signature of injured party  

Date

Signature of employee accepting report  

Date

Return this form to Supervisor on duty within 24 hours of incident.