

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 1094.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
0	2	17	17
(G)	(H)	(I)	(J)

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
43.00	749.00
(K)	(L)

Injury and Illness Types

Total number of ... (M)			
(1) Injuries	36	(4) Poisonings	0
(2) Skin disorders	0	(5) Hearing loss	0
(3) Respiratory conditions	0	(6) All other illnesses	0

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

Public reporting burden for this collection of information is estimated to average 50 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 required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Establishment information

Your establishment name CSU San Marcos
 Street 333 South Twin Oaks Valley Road
 City San Marcos State CA ZIP 92096-0001

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

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

OR

North American Industrial Classification (NAICS), if known (e.g.,*336212*)
611310 _ _ _ _ _

Employment information (if you don't have these figures, see the Worksheet on the back of this page to estimate.)

Annual average number of employees _____

Total hours worked by all employees last year _____

Sign here

Knowingly falsifying this document may result in a fine.

 Company executive Title
 () - / /
 Phone Date

OSHA Form 300A_2011

<u>Field Name</u>	<u>Field Value</u>	<u>Field Value Description</u>	<u>Operator Column Name</u>
Claimant Status	1	Open	claimant_status_code
	5	Closed	claimant_status_code
Claimant Type	2	Future Medical	claimant_type_code
	3	Indemnity	claimant_type_code
	4	Medical	claimant_type_code
	7	Pending	claimant_type_code
Incident Date	Last year	From: 2012/01/01 To: 2012/12/31	incident_date
Line of Insurance	2	Workers Compensation	insurance_type
Location	251	CSU San Marcos	insured_id