

# Log of Work-Related Injuries and Illnesses

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.

Year 2022



U.S. Department of Labor  
Occupational Safety and Health Administration

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.

Establishment Name: 1091 NORTHERN MORAIN WASTEWATER RECLAMATION

City: ISLAND LAKE

State: IL

Identify the person		Describe the case				Classify the case <i>CHECK ONLY ONE box for each case based on the most serious outcome for that case:</i>				Enter the number of days the injured or ill worker was:		Check the "Injury" column or choose one type of illness:					
(A) Case no.	(B) Employee's name	(C) Job title <i>(e.g., Welder)</i>	(D) Date of injury or onset of illness	(E) Where the event occurred <i>(e.g., Loading dock north end)</i>	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill <i>(e.g., Second degree burns on right forearm from acetylene torch)</i>	<u>Remained at Work</u>				Away from work	On job transfer or restriction	(M) Injury	Skin disorder	Respiratory condition	Poisoning	Hearing loss	All other illnesses
						Death (G)	Days away from work (H)	Job transfer or restriction (I)	Other recordable cases (J)	(K)	(L)	(1)	(2)	(3)	(4)	(5)	(6)
K191695	Mercado, Miguel	SEWAGE DISPOSAL PLANT & DRVERS	3/6/2022	64 South Circle	Allergic Reaction/Dermatitis, EYE(S), Replacing sewer pump/wastewater splashed in eye				X	0	0	X					
K356475	Pepin, Michael	Resident Engineering	8/5/2022	Intersection of River Rd and Vauper Dr	Strained shoulder/neck				X	0	0	X					

Page totals: 0 0 0 2 0 0 2 0 0 0 0 0

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.

Data for informational purposes only. The final completion of the OSHA form is the responsibility of the employer.

Injury  
(1)

Skin disorder  
(2)

Respiratory condition  
(3)

Poisoning  
(4)

Hearing loss  
(5)

All other illnesses  
(6)



# 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 20 CFR Part 1904.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms.

## Number of Cases

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

## Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
<b>0</b>	<b>0</b>
(K)	(L)

## Injury and Illness Types

Total number of ...	
(M)	
(1) Injuries	<b>2</b>
(2) Skin disorders	<b>0</b>
(3) Respiratory conditions	<b>0</b>
(4) Poisonings	<b>0</b>
(5) Hearing Loss	<b>0</b>
(6) All other illnesses	<b>0</b>

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

Public reporting burden for this collection of information is estimated to average 58 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

### Establishment information

Your establishment name **1091 NORTHERN MORAIN WASTEWATER RECLAMATION**

Street **PO BOX 240**

City **ISLAND LAKE** State **IL** ZIP **60042**

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

Annual average number of employees **0**

Total hours worked by all employees last year **0**

### Sign here

**Knowingly falsifying this document may result in a fine.**

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

Company executive Title

**1/18/2023**

Phone Date