Occupational Safety and Health Administration
Supplementary Record of
Occupational Injuries and Illnesses

U.S. Department of Labor

This form is required by Public Law 91-596 and must be kept in the establishment for 5 years.
Failure to maintain can result in the issuance of citations and assessment of penalties.

Case or File No.

Form Approved
O.M.B. No. 1218-0176

See OMB Disclosure Statement on reverse.

Employer

1. Name

2. Mail address (No. and street, city or town, State, and zip code)

3. Location, if different from mail address

Injured or Ill Employee

4 Name (First, middle, and last)

Social Security No.

5. Home address (No. and street, city or town, State, and zip code)

6. Age

7. Sex (Check one) Male ☐ Female ☐

8. Occupation (Enter regular job title, not the specific activity he was performing at the time of injury.)

9. Department (Enter name of department or division in which the injured person is regularly employed, even though he may have been temporarily working in another department at the time of injuiry.)

The Accident or Exposure to Occupational Illness

If accident or exposure occurred on employer's premises, give address of plant or establishment in which it occurred. Do not indicated department or division within the plant or establishment. If accident occurred outside employer's premises at an identifiable address, give that address. If it occurred on a public highway or at any other place which cannot be identified by number and street, please provide place references locating the place of injury as accurately as possible.

10. Place of accident or exposure (No. and street, city or town, State, and zip code)

11. Was place of accident or exposure on employer's premises? Yes ☐ No ☐

12. What was the employee doing when injured? (Be specific. If he was using tools or equipment or handling material, name them and tell what he was doing with them.)

13. How did the accident occur? (Describe fully the events which resulted in the injury or occupational illness. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. Use separate sheet for additional space.)

Occupational Injury or Occupational Illness

14. Describe the injury or illness in detail and indicate the part of body affected. (E.g., amputation of right index finger at second joint; fracture of ribs; lead poisoning; dermatitis of left hand, etc.)

15. Name the object or substance which directly injured the employee. (For example, the machine or thing he struck against or which struck him; the vapor or poison he inhaled or swallowed; the chemical or radiation which irriatated his skin; or in cases of strains, hernias, etc., the thing he was lifting, pulling, etc.)

16. Date of injury or initial diagnosis of occupational illness

17. Did employee die? (Check one) Yes ☐ No ☐

Other

18. Name and address of physician

19. If hospitalized, name and address of hospital

Date of report	Prepared by	Official position

OSHA No. 101 (Feb. 1981)

(See Next Page/Reverse)

SUPPLEMENTARY RECORD OF OCCUPATIONAL INJURIES AND ILLNESSES

To supplement the Log and Summary of Occupational Injuries and Illneses (OSHA No. 200), each establishment must maintain a record of each recordable occupational injury or illness. Worker's compensation, insurance, or other reports are acceptable as records if they contain all facts listed below or are supplemented to do so. If no suitable report is made for other purposes, this form (OSHA No. 101) may be used or the necessary facts can be listed on a separate plain sheet of paper. These records must also be available in the establishment without delay and at reasonable times for examination by representatives of the Department of Labor and the Department of Health and Human Services, and States accorded jurisdiction under the Act. The records must be maintained for a period of not less than five years following the end of the calendar year to which they relate.

Such records must contain at least the following facts:

1) About the employer - name, mail address, and location if different from mail address.

2) About the injured or ill employee - name, social security number, home address, age, sex, occupation, and department.

3) About the accident or exposure to occupational illness - place of accident or exposure, whether it was on employer's premises, what the employee was doing when injured, and how the accident occurred.

4) About the occupational injury or illness - description of the injury or illness, including part of the body affected, name of the object or substance which directly injured the employee; and date of injury or diagnosis of illness.

5) Other - name and address of physician; if hospitalized, name and address of hospital, date of report; and name and position of person preparing the report.

SEE *DEFINITIONS* ON THE BACK OF OSHA FORM 200.

OMB DISCLOSURE STATMENT

Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the 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 currently valid OMB control number. If you have any comments regarding this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to the OSHA Office of Statistics, Room N3644, 200 Constitution Avenue, NW, Washington, DC 20210

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE