

# OSHA's Form 300 (Rev. 01/2004) 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 2025  
**U.S. Department of Labor**  
 Occupational Safety and Health Administration



You must record information 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 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.

Form approved OMB no. 1218-0176

Establishment name BEE Steel, Inc.  
 City Grand Rapids State MI

| Identify the person |                        |                                 | Describe the case                                      |   |   | Classify the case   |                     |                             |                        | Enter the number of days the injured or ill worker was:  |                                       |          |               |                       |           |              |                     |
|---------------------|------------------------|---------------------------------|--|---|---|---|---------------------|-----------------------------|------------------------|--|---------------------------------------|----------|---------------|-----------------------|-----------|--------------|---------------------|
| (A)<br>Case No.     | (B)<br>Employee's Name | (C)<br>Job Title (e.g., Welder) | (D)<br>Date of injury or onset of illness<br>(mo./day) | (E)<br>Where the event occurred (e.g. Loading dock north end) | (F)<br>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) | CHECK ONLY ONE box for each case based on the most serious outcome for that case: |                     |                             |                        | Check the "injury" column or choose one type of illness: |                                       |          |               |                       |           |              |                     |
|                     |                        |                                 |  |   |   | Death   | Days away from work | Remained at work            |                        | Away From Work (days)                                    | On job transfer or restriction (days) | (M)      |               |                       |           |              |                     |
|                     |                        |                                 |  |   |   |   |                     | Job transfer or restriction | Other recordable cases |  |                                       | Injury   | Skin Disorder | Respiratory Condition | Poisoning | Hearing Loss | All other illnesses |
|                     |                        |                                 |  |   |   | (G)   | (H)                 | (I)                         | (J)                    | (K)  | (L)                                   | (1)      | (2)           | (3)                   | (4)       | (5)          | (6)                 |
|                     | Slavcho Dundalow       | Ironworker-JRM                  | 04/04/2025   | Floor on PT deck  | Slipped on icy plywood  | 0   | 50                  | 0                           | 0                      | 0  | 0                                     | 0        | 0             | 0                     | 0         | 0            | 0                   |
| <b>Page totals</b>  |                        |                                 |  |   |   | <b>0</b>  | <b>50</b>           | <b>0</b>                    | <b>0</b>               | <b>0</b>   | <b>0</b>                              | <b>0</b> | <b>0</b>      | <b>0</b>              | <b>0</b>  | <b>0</b>     | <b>0</b>            |

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

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instruction, 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 aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.

Injury (1)  
 Skin Disorder (2)  
 Respiratory Condition (3)  
 Poisoning (4)  
 Hearing Loss (5)  
 All other illnesses (6)

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

Year 2025  
U.S. Department of Labor



Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

All establishments covered by Part 1904 must complete this Summary page, even if no injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate.

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 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 |
|------------------------|--|--|--|
| <u>0</u>               | <u>1</u>                                       | <u>0</u>   | <u>0</u>                               |
| (G)                    | (H)  | (I)  | (J)                                    |

## Number of Days

| Total number of days away from work | Total number of days of job transfer or restriction |
|-------------------------------------|---|
| <u>50</u>                           | <u>0</u>  |
| (K)                                 | (L)   |

## Injury and Illness Types

| Total number of... (M)    |          |                         |          |
|---------------------------|----------|-------------------------|----------|
| (1) Injury                | <u>1</u> | (4) Poisoning           | <u>0</u> |
| (2) Skin Disorder         | <u>0</u> | (5) Hearing Loss        | <u>0</u> |
| (3) Respiratory Condition | <u>0</u> | (6) All Other Illnesses | <u>0</u> |

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 instruction, 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 aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave. NW, Washington, DC 20210. Do not send the completed forms to this office.

**Establishment information**

Your establishment name BEE Steel, Inc.

Street 2090 Celebration Drive Suite 209

City Grand Rapids State MI. 49525

Industry description (e.g., Manufacture of motor truck trailers)  
Construction

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

OR North American Industrial Classification (NAICS), if known (e.g., 336212)  
2 3 8 1

**Employment information**

Annual average number of employees 49

Total hours worked by all employees last year 95,752

**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.

Kraig Klootra President  
Company executive Title

616-363-6694 1/12/25  
Phone Date

# OSHA's Form 301

## Injuries and Illnesses Incident Report

**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.



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

Form approved OMB no. 1218-0176

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.

|              |                      |
|--------------|----------------------|
| Completed by | <u>Kraig Klootra</u> |
| Title        | <u>President</u>     |
| Phone        | <u>616+363+6694</u>  |
| Date         | <u>2/12/24</u>       |

### Information about the employee

- 1) Full Name Slavcho Dundalow
- 2) Street 508 Diamond Ave  
City Grand Rapids State MI Zip 49503
- 3) Date of birth 5/17/67
- 4) Date hired 3/1/06
- 5)  Male  
 Female

### Information about the physician or other health care professional

- 6) Name of physician or other health care professional  
Sara Chaffee, MD
- 7) If treatment was given away from the worksite, where was it given?  
Facility Concentra Medical Centers  
Street 2331 Alpine Ave NW  
City Grand Rapids State MI Zip 49544

- 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 1 (Transfer the case number from the Log after you record the case.)
- 11) Date of injury or illness 4/4/25
- 12) Time employee began work 7:00 A.M. AM/PM
- 13) Time of event A.M. 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."  
  
N/A
- 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."  
Slipped on icy plywood
- 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."  
Lower Extremities, Ankle, Right
- 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.  
N/A
- 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 Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.