

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.

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.

Form approved OMB no. 1218-0176

Establishment name Eagle Industrial Instrumentation, LLC

City Gonzales State Louisiana

| Identify the person | | Describe the case | | | | Classify the case | | | | 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 (e.g., Welder) | (D) Date of injury or onset of illness | (E) Where the event occurred (e.g., Loading dock north end) | (F) 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) | Remained at Work | | | | Away from work | On job transfer or restriction | (M) | | | | | |
| | | | | | | Death | Days away from work | Job transfer or restriction | Other recordable cases | (K) | (L) | Injury | Skin disorder | Respiratory condition | Poisoning | Hearing loss | All other illnesses |
| | | | | | | (G) | (H) | (I) | (J) | | | (1) | (2) | (3) | (4) | (5) | (6) |
| | | | month/day | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ days | ___ days | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | month/day | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ days | ___ days | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | month/day | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ days | ___ days | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| | | | month/day | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ days | ___ days | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | month/day | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ days | ___ days | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | month/day | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ days | ___ days | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | month/day | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ days | ___ days | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Page totals > _____

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 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.

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| | | | | | |
|--------|---------------|-----------------------|-----------|--------------|---------------------|
| Injury | Skin disorder | Respiratory condition | Poisoning | Hearing loss | All other illnesses |
| (1) | (2) | (3) | (4) | (5) | (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 29 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 |
| <u>0</u> | <u>0</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>0</u> | <u>0</u> |
| (K) | (L) |

Injury and Illness Types

| | | | |
|----------------------------|----------|-------------------------|----------|
| Total number of . . . (M) | | | |
| (1) Injuries | <u>0</u> | (4) Poisonings | <u>0</u> |
| (2) Skin disorders | <u>0</u> | (5) Hearing loss | <u>0</u> |
| (3) Respiratory conditions | <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 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 Eagle Industrial Instrumentation, LLC

Street 41073 Lee Drive

City Gonzales State LA ZIP 70737

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

Onsite Service of Industrial Instrumentation

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 1

Total hours worked by all employees last year 980

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.

| | |
|-----------------------|--------------|
| <u>John S Russell</u> | <u>Owner</u> |
| Company executive | Title |
| (225) 363 - 5707 | 1 9 2017 |
| Phone | Date |