

# Summary of Work-Related Injuries and Illnesses

Year 2008



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 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.

**Establishment information**

INDIANA UNIVERSITY--IUPUI

Your establishment name

Street 620 Union Drive

City Indianapolis State IN ZIP 46202-5167

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

Educational Institution

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

8221

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 12,372

Total hours worked by all employees last year 22,269,600

**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.

*Lynn A. Sinn* Assistant Director  
Company executive Worker's Compensation  
Phone 812-855-4847 Title 1/26/09  
Date

**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	38	1	284
(G)	(H)	(I)	(J)

NOTE: IF CASE INVOLVED BOTH DAYS AWAY FROM WORK AND RESTRICTED DAYS, ONLY COLUMN H IS CHECKED PER GUIDELINES.

**Number of Days**

Total number of days away from work	Total number of days of job transfer or restriction
422	311
(K)	(L)

NOTE: NEW FORM REVERSES COLUMN TITLES

**Injury and Illness Types**

Total number of . . . (M)			
(1) Injuries	261	(4) Poisonings	0
(2) Skin disorders	3	(5) Hearing loss	1
(3) Respiratory conditions	12	(6) All other illnesses	46

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 30 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.

cc: Risk Management, Environmental Health & Safety,  
Human Resources, IUPUI Health Services, Rich Strong