Attachment 1A

Census of Fatal Occupational Injuries
Data Elements Coded by States

- Reference State and year
- Injury or illness
- State of residence
- Date of birth
- Age
- Race
- Gender
- Industry code and narrative (North American Industrial Classification System (NAICS))
- Ownership (Federal, State, local, foreign, or other government; or private sector)
- Establishment size class
- Occupation code and narrative (Standard Occupational Classification (SOC))
- Employee status (Active duty military, self-employed, family business, working for pay, volunteer, institutionalized individuals, unknown)
- State of employment
- Date of injury and death
- State of injury and death
- County of injury
- Time of incident
- Nature of injury/illness (BLS Occupational Injury and Illness Classification System (OIICS))
- Part of body (BLS OIICS)
- Primary and secondary source of injury/illness (BLS OIICS)
- Event or exposure (BLS OIICS)
- Worker activity
- Location type (farm, street, mine, etc.)
- How the injury/illness occurred (narrative description; up to 500 characters)
- Source documents requested and received
- Link code (links fatalities resulting from a single incident)
- Foreign birth--country
- Impairments

Optional data elements

- Hispanic origin
- Length of time in occupation/current position/with employer
- Usual lifetime industry/occupation
- Time workday began
- Cause of injury/illness (ICD-10 external cause codes)
- Medical complications code
- Processing comments

Attachment 1B

Census of Fatal Occupational Injuries
Research File Data Elements

The following data elements are included on the CFOI Research File for each fatality record. This file is given to qualified researchers who sign a Letter of Agreement and agree to comply with BLS confidentiality policy.

1. Year of death
2. Region designation for State code
3. Report ID (unique 5-digit code)
4. Injury (illnesses are maintained as a separate file)
5. Race

6. Gender
7. Industry (Based on the Standard Industrial Classification (SIC) Manual / North American Industrial Classification System beginning with data for 2003)
8. Ownership (federal, state or local government; private)
9. Occupation (Based on the 1990 Census of Population Occupational Classification System / Standard Occupation Classification (SOC) beginning with 2003 data)
10. Employee status (wage and salary, self-employed, etc.)

11. Nature of injury/illness (Based on the 1992 BLS Occupational Injury and Illness Classification Structures [OIICS]) Coding structure adopted as a National standard by ANSI Z16.2 in September 1995.
12. Part of body affected (BLS OIICS)
13. Source of injury (BLS OIICS)
14. Secondary source of injury (BLS OIICS)
15. Event or exposure (BLS OIICS)

16. Worker activity (at the time of incident)
17. Hispanic origin
18. Location of incident (farm, street, mine, etc.)
19. Age (10-year intervals starting with less than 20)
20. Date of injury (day of the week, month, and year)

21. Days survived (number of days between injury and death)
22. Born in foreign country (name of continent)
23. Establishment sizes (5 employment size groups)
24. Length of time with employer (in years)
25. Urban or rural area

26. Time of incident (to the nearest hour)
27. How the injury occurred (narrative description up to 500 characters)

****

Additional data elements requested by NIOSH:

1. State codes
2. Date of birth
3. Date of death
4. Death certificate identification number
5. Narrative industry and occupation description

Followback questionnaire (CFOI-1) **Attachment 2A**

STATE LETTERHEAD

Dear:

It is with sincere regret that we must request your assistance during this difficult time (informant letter ONLY). We have learned of [decedent's name]'s death and that it may have occurred at work. We request your assistance in providing information that will help us to better understand the circumstances surrounding the incident. Please take a few minutes to complete this important information using the enclosed form ["or by sending us a copy of the report describing the incident" if respondent is an administrative agency.]

What we are asking:

We are committed to minimizing your effort in providing the requested information. Therefore, we have completed all of the information that is available to us. To ensure accuracy and completeness of information, we request that you:

1. check our entries and make any necessary corrections to the information reported;
2. complete any missing information that you have available; and
3. indicate which, if any, information you are unable to provide by writing in 'NA.'

If you prefer, you may provide the requested information by telephone. Information about whom to contact is provided below.

Reason for our request:

The purpose of this request is to obtain a better understanding of the hazards employees face in the workplace. Complete and accurate information on work-related injuries and fatalities is essential for developing effective strategies that may reduce the number of work-related injuries.

Authorizations for collecting information:

The information is being collected by the [State Agency] in cooperation with the Bureau of Labor Statistics of the U.S. Department of Labor. The Census of Fatal Occupational Injuries program is authorized by the Occupational Safety and Health Act of 1970 (Public Law 91-596) and has been approved by the Office of Management and Budget (OMB Number 1220-0133).

Confidentiality of your information:

Your voluntary cooperation is needed to ensure the information we collect is complete and accurate. The Bureau of Labor Statistics, its employees, agents, and partner statistical agencies, will use the information you provide for statistical purposes only and will hold the information in confidence to the full extent permitted by law. In accordance with the Confidential Information Protection and Statistical Efficiency Act of 2002 (Title 5 of Public Law 107-347) and other applicable Federal laws, your responses will not be disclosed in identifiable form without your informed consent.

Under written agreements to protect confidentiality and security of identifying information, a detailed data file will be made available to authorized researchers for conducting specific research projects. No personal or company identifiers will be released. Summary results will be made public to inform workers and employers about hazards in the workplace. Although we have taken every precaution to ensure the confidentiality of personal or company identifying information, it may be possible to recognize catastrophic or well-publicized events from data that are released.

To return your completed form:

We have enclosed an envelope to assist you in returning the form as soon as possible. If you have any questions about the form or would like to report the information by telephone, please contact [name and telephone number to be inserted by the individual State].

Thank you very much in advance for your assistance in providing valuable information that will help make workplaces safer.

Sincerely, ["With deepest sympathy," if sent to informant]

[State agency official]

Enclosures

Bureau of Labor Statistics **U.S. Department of Labor**
Census of Fatal
Occupational Injuries Report

This report is authorized by Public Law 91-596. Your voluntary cooperation is needed to make the results of this study comprehensive, accurate, and timely. The Bureau of Labor Statistics, its employees, agents, and partner statistical agencies, will use the information you provide for statistical purposes only and will hold the information in confidence to the full extent permitted by law. In accordance with the Confidential Information Protection and Statistical Efficiency Act of 2002 (Title 5 of Public Law 107-347) and other applicable Federal laws, your responses will not be disclosed in identifiable form without your informed consent.	Form Approved OMB No. 1220-0133 Approval Expires X/XX/20XX
ID	The Bureau estimates that it will take from 10 to 30 minutes to complete this form, with an average of 20 minutes, including time for gathering the information needed and completing the form. If you have any comments regarding this estimate or any other aspect of this data collection, including suggestions for reducing this burden, you may send them to the Bureau of Labor Statistics, CFOI Program, 2 Massachusetts Avenue, NE, Room 3180, Washington, D.C. 20212-0001. Do not send the completed form to this address. You do not have to complete this form if it does not display a currently valid OMB Control Number.

Return to:

For assistance call:

Instructions: Some information about the incident is already provided on this form. Please review this information and do the following:

- **Correct** any inaccurate information.
- **Add** any missing information.
- If you cannot answer a question, please **indicate** that you do **NOT** have sufficient information to answer the question.
- Please **contact** us if you have any questions regarding this form.

SECTION I. DECEASED WORKER AND EMPLOYER

NAME: _____

1. **Legal name:** *(Please print):* _____
   (Last) *(First)* *(Middle)*
2. **Social Security Number:** _____
3. **Employer at the time of the incident:**

_____
(Company name)

_____
(Street address)

_____
(City) *(State)* *(Zip code)*

(_____) _____
(Area code) *(Phone number)*

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ST ID

4. **Date of birth:** _____
(*Month*) (*Day*) (*Year*)

5. **Ethnicity and race:** *(Select one or more)*

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White

6. **Sex:** ❑ Male ❑ Female

7. **In what state did the deceased reside?** _____

SECTION II. EMPLOYMENT INFORMATION

1. **Which of the following BEST describes the deceased's employment status at the time of the incident?** *(Check only **ONE**)*

- ❑ Active duty, Armed Forces
- ❑ Self-employed, partner, owner of business, farm, or professional practice
  → *Check only **ONE**:* ❑ incorporated ❑ unincorporated
- ❑ Working for the family business, except owner (includes paid or unpaid work)
  → *Check only **ONE**:* ❑ incorporated ❑ unincorporated
- ❑ Working for pay or other compensation (such as room and board) in other than the family business
- ❑ Working as a volunteer without pay or other compensation
- ❑ Other (*Please specify)* _____
- ❑ Don't know

2. **Occupation of deceased at the time of the incident:** (*Examples include: cashier, drywall installer, farm foreman)* _____

3. **How long did the deceased work in the position held at the time of the incident?**

[ ] years [ ] months *(if less than 1 year)*

4. **How long was the deceased employed at the company or business?**

[ ] years [ ] months *(if less than 1 year)*

5. **How long did the deceased work in this occupation?**

[ ] years [ ] months *(if less than 1 year)*

6. **Which of the following <u>best</u> describes the type of employer the deceased was employed by?** *(Check only **ONE**)*

- ❑ a private company or self-employed
- ❑ a local government agency
- ❑ a State government agency
- ❑ a Federal government agency
- ❑ a foreign or international government agency
- ❑ other governmental body, such as a regional or interstate commission

ST ID

7. **Describe the nature of the business or the main type of activity performed by the employer at the establishment.** (*Examples include: manufacturer of storage batteries, grocery store, computer programming services, etc.)*

_____

8. **On average, about how many persons work for the employer at the actual location or worksite where the incident occurred?** *(Check only **ONE**)*

❑ 1-10 ❑ 11-19 ❑ 20-49 ❑ 50-99 ❑ 100 or more ❑ don't know

9. **Please describe the type of business the deceased worked in the longest during his/her lifetime** (for example: *grocery store, dairy farm, automotive repair, etc.*):

_____

10. **In what occupation did the deceased work the longest during his/her lifetime?** _____

SECTION III. INFORMATION ABOUT THE INCIDENT

1. **Date of death:** _____
(Month) (Day) (Year)

2. **State in which death occurred:** _____

3. **Date the incident occurred:** _____
(Month) (Day) (Year)

4. **Where did this incident occur?**

State: _____

County: _____

Type of location (*Examples include: farm, highway, bank, etc.):*

_____

5. **Did the incident occur on the employer's premises?**

❑ no
❑ yes ⟶ ***If YES*, where did the incident occur?**

❑ in a work area
❑ in the company parking lot
❑ on an outside walkway
❑ in a recreational area
❑ in a hallway, stairway, rest room, or cafeteria
❑ some other place, *please specify:*
_____
❑ don't know

ST ID

6. What was the deceased doing at the time of the incident? *(Mark **ALL** that apply.)*

- ❑ normal commute between home and usual work location
- ❑ job-related errand or travel other than commuting to or from work
- ❑ attending training provided or required by the employer
- ❑ routine or typical work activity (*Please specify):* _____
- ❑ other activity on the employer premises:
- ❑ work-related activity (*Please specify):* _____
- ❑ non-work-related activity (*Please specify):* _____
- ❑ non work-related personal business
- ❑ don't know

7. What time did the incident occur? [ ] *Check only **ONE**:* ❑ AM ❑ PM

8. What time did the deceased's workday begin on the day the incident occurred? [ ] *Check only **ONE**:* ❑ AM ❑ PM

9. The injury/illness resulted from: *(Check the **MOST** accurate statement.)*

- ❑ an incident, such as a fall, explosion, shooting, etc.
- ❑ an exposure to a chemical, substance, or environmental factor lasting a day or less
- ❑ an exposure to a chemical, substance, or environmental factor lasting more than a day
- ❑ heart attack/stroke
- ❑ natural causes other than heart attack or stroke
- ❑ other (*Please specify):* _____

10. Please provide more specific details to describe the injury/illness and the events which resulted in the injury/illness:

a. Include information about how the injury/illness occurred.

b. Identify any equipment, objects, or substances involved in the incident and describe how they were involved. *(Please use additional pages if more space is needed.)*

_____

_____

_____

_____

SECTION IV. RESPONDENT IDENTIFICATION

Please provide the following information:

1. Your name: _____

2. Your job title: _____

3. Your daytime phone number: (_____) _____
(Area code) *(Phone number)*

4. Date you completed this form: _____
(Month) *(Day)* *(Year)*

Letter requesting source documents **Attachment 2B**

STATE LETTERHEAD

Dear:

The Occupational Safety and Health Act of 1970 (PL 91-596) requires the Secretary of Labor to develop and maintain an effective program of collection, compilation, and analysis of occupational safety and health statistics. In response to the need for complete, accurate, and timely data for occupational fatalities occurring in the United States, the Bureau of Labor Statistics (BLS), in cooperation with (State Agency), implemented the Census of Fatal Occupational Injuries (CFOI) program in 1992. The CFOI program has been approved by the Office of Management and Budget (OMB Number 1220-0133).

To ensure complete, up-to-date fatality information, we collect data from various sources:

- death certificates;
- Federal and State workers' compensation reports;
- reports to Federal and State regulatory agencies;
- medical examiner and autopsy reports;
- highway and police reports; and
- other reports available to State agencies.

We would appreciate your assistance in collecting these data. We would like to receive, on a flow basis, copies of any documents or reports you receive concerning work-related fatalities. We may also request documents for fatalities identified by other sources as work-related to obtain additional information. We will use information contained on these documents to determine if the fatality occurred while the person was in a work status. The worker's name, Social Security Number, date of birth, date of injury, date of death, and employer's name are needed to match reports from other sources to ensure that each fatality is counted only once.

Your voluntary cooperation is needed to ensure the information we collect is complete and accurate. The Bureau of Labor Statistics, its employees, agents, and partner statistical agencies, will use the information you provide for statistical purposes only and will hold the information in confidence to the full extent permitted by law. In accordance with the Confidential Information Protection and Statistical Efficiency Act of 2002 (Title 5 of Public Law 107-347) and other applicable Federal laws, your responses will not be disclosed in identifiable form without your informed consent.

Under written agreements to protect confidentiality and security of identifying information, a detailed datafile will be made available to authorized researchers for conducting specific research projects. No personal or company identifiers will be released. Summary results will be made public to inform workers and employers about hazards in the workplace. Although we have taken every precaution to ensure the confidentiality of personal or company identifying information, it may be possible to recognize catastrophic or well-publicized events from data that are released.

[We would like to meet with you at your convenience to discuss this program in more detail.] Please call (State contact name) at (telephone number) if you have any questions regarding the fatality census or to schedule an appointment with us.

Sincerely yours,

(State official's name)

FAX requesting death certificates **Attachment 2C**

STATE LETTERHEAD

FAX TRANSMISSION

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**********************************************************************
This document and any attachments are confidential and intended solely
for the individual or entity to whom they are addressed.  If you have
received this fax in error, destroy it immediately.
**********************************************************************
```

Date:

PLEASE DELIVER TO: [Name, address, fax, and phone]

Total number of pages including this sheet: _____

Please fax or mail Death Certificates for the persons listed below to:

[Name, address, Fax, and Phone of CFOI state agency]

Thank you for your time.

[Name of CFOI contact]

Name	**SS#**	**Date of death**
John Doe	xxx-yy-zzzz	mm/dd/yyyy
Jane Smith	yyy-xx-aaaa	mm/dd/yyyy

End of list