Survey of Occupational Injuries and Illnesses, 2007

U.S. Department of Labor, Bureau of Labor Statistics

FAX Response Form

Complete and FAX to us at (XXX) XXX-XXXX

If there were few or no work-related injuries and illnesses at this establishment in calendar year 2007, you can complete and fax this form, along with forms for any cases with days away from work, in order to fulfill your obligation in responding to this mandatory survey. If you respond via this FAX, **do not mail in your survey form or reply by the Internet or e-mail**.

1. Refer to your Reporting Site's OSHA Forms for Recording Work-Related Injuries and Illnesses.
2. If more than one establishment is noted on the front cover under Reporting Site, be sure to include the OSHA Form 300A for all of the specified establishments.
3. If any total is zero on your OSHA Form 300A, write "0" in that total's space below.
4. The total Number of Cases recorded in G + H + I + J must equal the total Injury and Illness Types recorded in M (1 + 2 + 3 + 4 + 5 + 6).

COMPANY NAME and **REPORTING SITE** (as it appears on the cover of your survey booklet):

_____

Establishment ID Number (appears directly under "***Your Company Address***:")

99 - _____ - 2007

Contact Name and Title _____

Telephone Number (ext) ( ) -

Date / /

FAX number ( ) -

1 Enter the annual average number of employees for 2007. → _____

2. Enter the total hours worked by all employees for 2007. → _____

3. Did you have ANY occupational injuries or illnesses during 2007?
   ❑ Yes. **Complete the Next Section directly below.** ❑ No. **You are done. Please FAX this (XXX) XXX-XXXX.**

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
_____	_____	_____	_____
(G)	**(H)**	(I)	(J)

NOTE: → **If any cases are recorded in Column H, please complete a Case with Days Away from Work form for each case and include with your FAX return.**

Number of Days

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

Injury and Illness Types

Total number of …

	(M)		(M)
(1) Injuries	_____	(4) Poisonings	_____
(2) Skin disorders	_____	(5) Hearing loss	_____
(3) Respiratory conditions	_____	(6) All other illnesses	_____

OMB No. 1220-0045
Approval expires xx-xx-xx
BLS-9300 FAX

Case with Days Away from Work

Tell us about a 2007 occupational injury or illness **only** if it resulted in days away from work. To find out which case(s) you should report, read the instructions at the beginning of ***Section 3: Reporting Cases with Days Away from Work***.

Tell us about the Case

Go to your completed OSHA Form 300. Copy the case information from that form into the spaces below.

Employee's name (column B)	**Job title** (column C)	**Date of injury or onset of illness** (column D)	**Number of days away from work** (column K)	**Number of days of job transfer or restriction** (column L)
		___/___/**07** *month day year*		

Tell us about the Employee

1. **Check the category which *best* describes the employee's regular type of job or work**: (optional)

- ❑ Office, professional, business, or management staff
- ❑ Sales
- ❑ Product assembly, product manufacture
- ❑ Repair, installation or service of machines, equipment
- ❑ Construction
- ❑ Other:_____
- ❑ Healthcare
- ❑ Delivery or driving
- ❑ Food service
- ❑ Cleaning, maintenance of building, grounds
- ❑ Material handling *(e.g.* stocking, loading/unloading, moving, etc.)
- ❑ Farming

2. **Employee's race or ethnic background:** (optional-check one or more)

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Not available

NOTE: You may either answer questions (3) to (11) or attach a copy of a supplementary document that answers them.

3. **Employee's age: _____ *OR* date of birth:** _____/_____/_____ *month day year*

4. **Employee's date hired:** _____/_____/_____ *month day year*

***OR* check length of service at establishment when incident occurred:**

- ❑ Less than 3 months
- ❑ From 3 to 11 months
- ❑ From 1 to 5 years
- ❑ More than 5 years

5. **Employee's gender:**

- ❑ Male
- ❑ Female

Tell us about the Incident

Answer the questions below or attach a copy of a supplementary document that answers them.

6. **Time employee began work:** _____ ❑ *am* ❑ *pm*

7. **Time of event:** _____ ❑ *am* ❑ *pm* *OR* ❑ *Check if time cannot be determined*

Event occurred: ❑ *before* ❑ *during* ❑ *after* work shift

8. **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."

9. **What happened?** Tell us how the injury or illness 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."

10. **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."

11. **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	P	S	E	SS	OCC