



Survey of Occupational Injuries and Illnesses, 2010

YOUR RESPONSE IS REQUIRED BY LAW IN 30 DAYS.

Please correct your company address as needed.

**For your convenience, you can submit your survey response
on our website at <https://idcf.bls.gov>.**

We estimate it will take you an average of 24 minutes to complete this survey (ranging from 10 minutes to 5 hours per package), including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing this information. If you have any comments regarding the estimates or any other aspect of this survey, including suggestions for reducing this burden, please send them to the Bureau of Labor Statistics, Occupational Safety and Health Statistics (1220-0045), 2 Massachusetts Avenue, N.E., Washington, DC 20212. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. **DO NOT SEND THE COMPLETED FORM TO THIS ADDRESS.**

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.

OMB No. 1220-0045
BLS-9300 N06

Steps to Complete this Survey

This survey requires employers to provide information about work-related injuries and illnesses based upon the information you have maintained for Calendar Year 2010 on your Occupational Safety and Health Administration (OSHA) *Forms for Recording Work-Related Injuries and Illnesses*. Copies of these forms were mailed to you in late 2009. Under Public Law 91-596, all establishments that receive this **mandatory** survey must complete and return it within 30 days, even if they had **no** work-related injuries and illnesses during 2010. The instructions below outline the steps to complete the survey regardless of whether your establishment did or did not have injuries or illnesses in 2010.

- Step 1:** Complete this survey only for the establishment(s) noted on the front cover under **“Report for this Location.”** If you are unsure, please call the number(s) listed on the front of this form as **“For Help Call:.”**
- Step 2:** Check **“Your Company Address”** printed on the front cover. Make any necessary corrections directly on the front cover.
- Step 3:** Refer to your establishment’s OSHA *Forms for Recording Work-Related Injuries and Illnesses*. Copies of these forms were mailed to you in late 2009.

- If you had no work-related injuries and illnesses in 2010, answer all questions in Section 1 of the survey.

DATA COLLECTION AGENCY
SURVEY STAFF
123 MAIN STREET
MY CITY, US 12345-0000

Address for Return Envelope:
DATA COLLECTION AGENCY
SURVEY STAFF
123 MAIN STREET
MY CITY, US 12345-0000

Your Establishment ID:
77-123456789-3

Report for this Location:
SAME AS YOUR COMPANY ADDRESS

For Help Call: (555) 111-2222

Your Company Address:
YOUR COMPANY NAME
987 YOUR STREET
YOUR CITY, US 98765-0000

Account Number:
302123456789

Temporary Password:
9876aNsU

77-123456789-1
2007-1 485510 12 P 60 00

- If you had at least one work-related injury or illness in 2010, answer all questions in Sections 1 and 2 of the survey.
- For any work-related injuries or illnesses with days away from work which occurred in 2010, also complete Section 3.

Step 4: Write the name of the person who completed this survey in case we have questions in Section 4: Contact Information on the back cover of this survey.

Step 5: Return this survey and any attachments in the enclosed envelope within 30 days of the date your establishment received it. Alternative methods of reporting, such as e-mail or the Internet, are explained in a brochure in the middle of this booklet.

Section 1: Establishment Information

Instructions: Using your completed Calendar Year 2010 *Summary of Work-Related Injuries and Illnesses* (OSHA Form 300A), copy the establishment information into the boxes. If these numbers are not available on your OSHA Form 300A, or if your establishment does not keep records needed to answer (2) and (3) below, you can estimate using the steps that follow on the next page.

1. Enter your account number from the front cover. _____ →
2. Enter the annual average number of employees for 2010. _____ →
3. Enter the total hours worked by all employees for 2010. _____ →
4. Check any conditions that might have affected your answers to questions 2 and 3 above during 2010:

<input type="checkbox"/> Strike or lockout	<input type="checkbox"/> Shorter work schedules or fewer pay periods than usual
<input type="checkbox"/> Shutdown or layoff	<input type="checkbox"/> Longer work schedules or more pay periods than usual
<input type="checkbox"/> Seasonal work	<input type="checkbox"/> Other reason: _____
<input type="checkbox"/> Natural disaster or adverse weather conditions	<input type="checkbox"/> Nothing unusual happened to affect our employment or hours figures
5. Did you have ANY work-related injuries or illnesses during 2010?
 - Yes. Go to Section 2: Summary of Work-Related Injuries and Illnesses, 2010, directly below.
 - No. Go to Section 4: Contact Information, on the back cover.

Section 2: Summary of Work-Related Injuries and Illnesses, 2010

Instructions:

1. Refer to the OSHA *Forms for Recording Work-Related Injuries and Illnesses* for the location referenced on the front cover of the survey under “**Report for this Location.**” If you prefer, you may enclose a photocopy of your *Summary of Work-Related Injuries and Illnesses* (OSHA Form 300A).
2. If more than one establishment is noted on the front cover of this survey, 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).

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)

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

If you had any work-related deaths in 2010, please tell us on the line below where you assigned/classified each death within the list of items (M1) through (M6) provided under **Injury and Illness Types** above (e.g., “fatal case was due to injury resulting from fall” or “death resulted from respiratory conditions”)_____

Steps to estimate annual average number of employees for 2010:

Step 1:

To calculate the annual average number of employees your establishment paid during 2010, you must calculate the total number of employees your establishment paid for all periods. Add the number of employees your establishment paid in every pay period during calendar year 2010. Count all employees that you paid at any time during the year and include full-time, part-time, temporary, seasonal, salaried, and hourly workers. Note that pay periods could be monthly, weekly, bi-weekly, etc.

Example:

Acme Construction paid its employees in 12 pay periods during 2010:

<u>Pay Period</u>	<u>Number of Employees Paid</u> <u>Per Pay Period</u>
1	30
2	0
3	35
4	37
5	37
6	40
7	43
8	42
9	37
10	35
11	30
12	<u>+26</u>
	392 (total number of employees paid over all pay periods)

Step 2:

Divide the total number of employees (from step 1) by the number of pay periods your establishment had in 2010. Be sure to count any pay periods when you had no (zero) employees.

Example:

Acme Construction had 12 pay periods and paid a total of 392 employees during these pay periods.

392 divided by 12 = 32.67

Step 3:

Round the answer you computed in step 2 to the next highest whole number. Write that number in the box for Section 1, question 2 on the previous page.

Example:

Acme would round 32.67 to 33.

Steps to estimate total hours worked by all employees for 2010:

Step 1:

Determine the number of full-time employees at your establishment.

Example:

Of Acme's 33 employees in 2010, 28 were full-time.

Step 2:

Determine the number of hours generally worked by a full-time employee for a year. Multiply the number of full-time employees you calculated in step 1 by this number. This total number of full-time hours worked should exclude vacation, sick leave, holidays, and any other non-work time.

Example:

Each of Acme's 28 full-time employees worked an average of 2,000 hours per year after excluding vacation, sick leave, holidays, and other non-work time. This works out to 40 hours per week for 50 weeks of the year.

28	full-time employees
<u>X 2,000</u>	hours per year
56,000	total full-time hours

Step 3:

Determine the number of hours of overtime worked by your full-time employees.

Determine the number of regular hours worked by your non-full-time employees. (Non-full-time employees include part-time, seasonal, and temporary employees.)

Add these numbers to the number you calculated in step 2 above. This is the estimated number of hours worked by all of your employees – full-time and non-full-time – during 2010. Write this number in Section 1, question 3 on the previous page.

Example:

Acme's 28 full-time employees worked a total of 2,800 hours of overtime during 2010 and 56,000 regular hours. Acme's 5 part-time employees worked a total of 2,715 hours during 2010.

56,000	full-time hours from step 2
2,800	over time hours
<u>+ 2,715</u>	part-time hours
61,515	total hours worked

Section 3: Reporting Cases with Days Away from Work

Instructions:

1. If you had **NO** cases with days away from work in Column H, you are finished with the survey. Go to Section 4: Contact Information on the back cover of this booklet and provide information for the person who completed this survey.
2. If you had cases with days away from work in Column H, please complete this Section 3.
3. You should only report cases with days away from work. To identify the individual cases to report, follow these steps:

Step 1: Go to your completed OSHA Form 300. Note each case that has a check in column (H). These are the only cases you should report. See the sample in Step 3.

Step 2: Fill out one Case with Days Away from Work form for each case that you identified in Step 1. You can find most of the information on a supplementary document such as the *Injury and Illness Incident Report* (OSHA Form 301), a workers' compensation report, an accident report, or an insurance form.

Step 3: If more than one establishment is noted on the front cover under "**Report for this Location,**" be sure to look at all your OSHA Form 300's to find which cases to report.

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

Attention: This form contains information relating to personal health and must be used to review that possible. The OSHA will not be responsible for the content of the information in this form used for non-OSHA safety and health purposes.

Year 20...
U.S. Department of Labor
Occupational Safety and Health Administration

Identify the person
Name: _____
Employee's name: _____
Job title: _____
Department: _____

Describe the case
Date: _____
Time: _____
Location: _____
Description of injury or illness: _____

Classify the case
OSHA 300-101: _____
OSHA 300-102: _____
OSHA 300-103: _____
OSHA 300-104: _____
OSHA 300-105: _____
OSHA 300-106: _____
OSHA 300-107: _____
OSHA 300-108: _____
OSHA 300-109: _____
OSHA 300-110: _____
OSHA 300-111: _____
OSHA 300-112: _____
OSHA 300-113: _____
OSHA 300-114: _____
OSHA 300-115: _____
OSHA 300-116: _____
OSHA 300-117: _____
OSHA 300-118: _____
OSHA 300-119: _____
OSHA 300-120: _____

Check for "Days" column
Days away from work: _____
Job transfer or restriction: _____
Work restriction: _____
Medical treatment beyond first aid: _____
Loss of consciousness: _____
Loss of workday: _____
Days away from work: _____
Job transfer or restriction: _____
Work restriction: _____
Medical treatment beyond first aid: _____
Loss of consciousness: _____
Loss of workday: _____

Section 3 asks about injuries or illnesses with a check in Column H, days away from work

Step 4: We have designed this survey to ensure that you do not have to report more than approximately 15 cases. If you have significantly more than 15 cases, please go to Section 5: If You Need Help . . . at the back of this booklet and call the phone number(s) listed for your State for assistance. If you need more Case with Days Away from Work forms, you may either photocopy a blank form or go to Section 5: If You Need Help . . . at the back of this booklet and call the phone number(s) listed for your State.

Step 5: When you are finished, proceed to Section 4: Contact Information on the back cover of this booklet and provide information for the person who completed this survey.

Case with Days Away from Work

Tell us about a 2010 work-related 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)
_____	_____	____/____/____ <small>month day year</small>	_____	_____

Tell us about the Employee

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

M	S	E
<input type="checkbox"/> Office, professional, business, or management staff	<input type="checkbox"/> Healthcare	
<input type="checkbox"/> Sales	<input type="checkbox"/> Delivery or driving	
<input type="checkbox"/> Product assembly, product manufacture	<input type="checkbox"/> Food service	
<input type="checkbox"/> Repair, installation or service of machines, equipment	<input type="checkbox"/> Cleaning, maintenance of building, grounds	
<input type="checkbox"/> Construction	<input type="checkbox"/> Material handling (e.g. stocking, loading/unloading, moving, etc.)	
<input type="checkbox"/> Other: _____	<input type="checkbox"/> 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 (13) 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. Was employee treated in an emergency room? yes no
7. Was employee hospitalized overnight as an in-patient? yes no
8. Time employee began work: _____ am pm
9. Time of event: _____ am pm OR Check if time cannot be determined
-
- Event occurred: before during after work shift
10. 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."
11. 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."
12. 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."
13. 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.

Case with Days Away from Work

Tell us about a 2010 work-related 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)
_____	_____	____/____/____ 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)

<input type="checkbox"/> Office, professional, business, or administrative work	<input type="checkbox"/> Healthcare
<input type="checkbox"/> Retail or wholesale trade	<input type="checkbox"/> Dining or drinking
<input type="checkbox"/> Services	<input type="checkbox"/> Food service
<input type="checkbox"/> Manufacturing	<input type="checkbox"/> Oil, gas, or mining
<input type="checkbox"/> Construction	<input type="checkbox"/> Material handling (e.g., stocking, loading/unloading, moving, etc.)
<input type="checkbox"/> Management staff	<input type="checkbox"/> Farming or driving
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Food service
	<input type="checkbox"/> Cleaning, maintenance
	<input type="checkbox"/> Material handling (e.g., stocking, loading/unloading, moving, etc.)
	<input type="checkbox"/> Farming

Tell us about the Case

2. Employee's race or ethnic background: (optional, check one or more) Go to your completed OSHA Form 300. Copy the case information from that form into the spaces below.

<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Not available
<input type="checkbox"/> Other: _____						

NOTE: You may either answer questions (3) to (13) or attach a copy of a supplementary document that answers them.

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

Not available

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

Not available

OR check length of service at establishment when incident occurred:

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

Less than 3 months

From 3 to 11 months

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

From 1 to 5 years

More than 5 years

5. Employee's gender:

Male

Female

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. Was employee treated in an emergency room? yes no

7. Was employee hospitalized overnight as an in-patient? yes no

8. Time employee began work: ____ am pm

9. Time of event: ____ am pm OR Check if time cannot be determined

Tell us about the Incident

Event occurred: before during after work shift

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

10. What was the employee doing just before the incident occurred?

6. Was employee treated in an emergency room? yes no

7. Was employee hospitalized overnight as an in-patient? yes no

8. Time employee began work: ____ am pm

9. Time of event: ____ am pm OR Check if time cannot be determined

11. 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."

12. 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."

13. 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.

12. 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."

13. 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.

Case with Days Away from Work

Tell us about a 2010 work-related 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)
_____	_____	____/____/____ 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)

<input type="checkbox"/> Office, professional, business, or management staff	<input type="checkbox"/> Healthcare
<input type="checkbox"/> Sales	<input type="checkbox"/> Driver or delivery
<input type="checkbox"/> Construction	<input type="checkbox"/> Food service
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Cleaning, maintenance, or building grounds

Tell us about the Case with Days Away from Work

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

<input type="checkbox"/> Office, professional, business, or management staff	<input type="checkbox"/> Health care (loading, moving, etc.)
<input type="checkbox"/> Sales	<input type="checkbox"/> Delivery or driving
<input type="checkbox"/> Construction	<input type="checkbox"/> Food service
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Cleaning, maintenance, or building grounds

2. Employee's race or ethnic background: (optional - check one or more) Report, consultation of service from American Indian or Alaska Native, or machine, equipment

<input type="checkbox"/> Asian	<input type="checkbox"/> Material handling (e.g. stacking, loading/unloading, moving, etc.)
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Farming
<input type="checkbox"/> Hispanic or Latino	
<input type="checkbox"/> White	
<input type="checkbox"/> American Indian or Alaska Native	
<input type="checkbox"/> Not available	
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	

NOTE: You may either answer questions (3) to (13) 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

Case with Days Away from Work

5. Employee's age: _____ OR date of birth: ____/____/____
month day year

6. Tell us about a 2010 work-related 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**.

7. Employee's gender: Male Female

8. From 3 to 11 months

9. From 1 to 5 years

10. More than 5 years

Tell us about the Incident

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

6. Was employee treated in an emergency room? yes no

7. Was employee hospitalized overnight as an in-patient? yes no

8. Time employee began work: ____ am ____ pm

9. Time of event: ____ am ____ pm OR Check if time cannot be determined

Tell us about the Incident

Event occurred: before during after work shift

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

10. What was the employee doing just before the incident occurred?

6. Was employee treated in an emergency room? yes no

7. Was employee hospitalized overnight as an in-patient? yes no

8. Time employee began work: ____ am ____ pm

9. Time of event: ____ am ____ pm OR Check if time cannot be determined

11. 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."

12. 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."

13. 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.

12. 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."

13. 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.

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)
		____/____/10 month day year		

Tell us about the Employee

Tell us about the Incident

1. Check the category which best describes the employee's regular type

Office, professional, business, or management staff	Healthcare	Delivery or driving	Food service	Cleaning, maintenance of building, grounds	Material handling (e.g. stocking, loading/unloading, moving, etc.)	Construction	Farming	Other:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Printed name		Telephone number						

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

6. Was employee treated in an emergency room? yes no

7. Was employee hospitalized overnight as an in-patient? yes no

8. Time employee began work: _____ am pm

9. Time of event: _____ am pm OR _____ () -
Check if time cannot be determined

Event occurred: before during after work shift

10. 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."

11. **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."

12. **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."

13. **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.

Illinois (217) 524-2098 (217) 558-4122 fax	Maine (207) 623-7903, 7904 (207) 623-7937 fax
Indiana (317) 232-2668 (317) 233-3790 fax	Maryland (410) 767-2373, 2382, 2384 (410) 333-7909 fax
Iowa (515) 281-5151 (515) 242-5076 fax	Massachusetts (617) 626-6945 (617) 626-6944 fax
Kansas (785) 296-1640 (785) 296-2151 fax	Michigan (517) 322-1848 (517) 322-5117 fax
Kentucky (502) 564-4137, 4259, 4136 (502) 564-0091 fax	Minnesota (888) 589-6322 (651) 284-5726 fax
Louisiana (225) 342-3126 (225) 342-3269 fax	Mississippi (404) 893-8344, 1934 (404) 893-8343 fax

Section 4: Contact Information

Fill in the name, title, and phone number of the person who completed this survey in case we have questions.

Printed name _____ Telephone number _____

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

American Indian or Alaska Native _____ / _____ / _____
Title _____ Today's date _____

Use the return envelope to send us the **entire package** -- everything that we sent you -- within 30 days of the date your establishment received it. If the return envelope is missing, send the **entire package** to the return address on the front cover (look for **Address for Return Envelope**).

NOTE: You may either answer questions (3) to (13) or attach a copy of a supplementary document that answers them.

Section 5: If You Need Help . . .

If you have any questions or if you need help completing this survey, call the phone number(s) that is listed below for your State. The phone number(s) may be for an office outside your State, but they will be able to help you. If you prefer to write, send your letter to the return address on the front of this package. **OR check length of service at establishment when incident occurred**

Alabama (334) 242-3461, 3463 (334) 240-3417 fax	District of Columbia (202) 442-9010, 5926, 5930
Alaska (907) 465-4539 (907) 465-4539	Florida (850) 413-1611 (850) 922-0024 fax
Arizona (602) 542-3739 (602) 542-6360 fax	Georgia (404) 679-1746, 1747, 1656 (404) 679-0520 fax
Arkansas (501) 682-4509 (501) 682-4754 fax	Guam (671) 475-7056 (671) 475-7063 fax
California (415) 703-3020 (415) 703-3029 fax	Hawaii (808) 586-9001 (808) 586-9022 fax
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