U.S. Department of Labor
Bureau of Labor Statistics

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.

OSHA's Form 300A
Summary of Work-Related Injuries and Illnesses
Year 20__
U.S. Department of Labor
Number of Cases
Number of Days
Injury and Illness Types
Establishment information
Employment information
Sign here

Copy this information to Section 2 of this survey.

Copy this information to Section 1 of this survey.

- 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

Copy your account number from the label to Section 1.

- 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:

❑ Strike or lockout
❑ Shutdown or layoff
❑ Seasonal work
❑ Natural disaster or adverse weather conditions
❑ Shorter work schedules or fewer pay periods than usual
❑ Longer work schedules or more pay periods than usual
❑ Other reason: ______________________________
❑ 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:

Pay Period	Number of Employees Paid Per Pay Period
1	30
2	0
3	35
4	37
5	37
6	40
7	43
8	42
9	37
10	35
11	30
12	+26
	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
X 2,000	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
+ 2,715	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

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

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)
____________	____________	___/___/10 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)

N	P	S	E	SS	OCC

- ❑ 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 (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)
______________	______________	___/___/10 (month day year)	________	________

Tell us about the Employee

N	P	S	E	SS	OCC

1. **Check the category which *best* describes the employee's regular type of job or work**: (optional)
   - ❑ Office, professional, business, or management staff
   - ❑ Sales
   - ❑ Production, assembly, product manufacture
   - ❑ Repair, installation or service of machines, equipment
   - ❑ Construction
   - ❑ Other: ____________________
   - ❑ Healthcare
   - ❑ Delivery or driving
   - ❑ Food service
   - ❑ Cleaning, maintenance of buildings, 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 (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)
______	______	___/___/10 *month day year*	______	______

N	P	S	E	SS	OCC

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 buildings, 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 (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.

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		

N	P	S	E	SS	OCC

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 (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.

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*	Ext.	( ) - *Fax number*
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***).

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.

Alabama
(334) 242-3461, 3463
(334) 240-3417 fax

Alaska
(907) 465-4539
(907) 465-4506 fax

Arizona
(602) 542-3739
(602) 542-6360 fax

Arkansas
(501) 682-4509
(501) 682-4754 fax

California
(415) 703-3020
(415) 703-3029 fax

Colorado
(816) 285-7146
(972) 850-4810 fax

Connecticut
(860) 263-6941
(860) 263-6950 fax

Delaware
(302) 761-8221
(302) 762-3590 fax

District of Columbia
(202) 442-9010, 5926, 5930
(202) 442-4833 fax

Florida
(850) 413-1611
(850) 922-0024 fax

Georgia
(404) 679-1746, 1747, 1656
(404) 679-0520 fax

Guam
(671) 475-7056
(671) 475-7063 fax

Hawaii
(808) 586-9001
(808) 586-9022 fax

Idaho
(415) 625-2275, 2271
(415) 625-2356 fax

Illinois
(217) 524-2098
(217) 558-4122 fax

Indiana
(317) 232-2668
(317) 233-3790 fax

Iowa
(515) 281-5151
(515) 242-5076 fax

Kansas
(785) 296-1640
(785) 296-2151 fax

Kentucky
(502) 564-4137, 4259, 4136
(502) 564-0091 fax

Louisiana
(225) 342-3126
(225) 342-3269 fax

Maine
(207) 623-7903, 7904
(207) 623-7937 fax

Maryland
(410) 767-2373, 2382, 2384
(410) 333-7909 fax

Massachusetts
(617) 626-6945
(617) 626-6944 fax

Michigan
(517) 322-1848
(517) 322-5117 fax

Minnesota
(888) 589-6322
(651) 284-5726 fax

Mississippi
(404) 893-8344, 1934
(404) 893-8343 fax

Missouri
(573) 751-3802, 2663, 2454
(573) 751-2319 fax
Montana
(800) 541-3904
(406) 444-2638 fax
Nebraska
(402) 471-3547, 1545
(800) 599-5155
(402) 742-2352 fax
Nevada
(866) 931-1215
(775) 684-7081
(775) 687-3826 fax
New Hampshire
(617) 565-2302
(617) 565-3847 fax
New Jersey
(609) 292-8999
(609) 633-0618 fax
New Mexico
(505) 476-8740
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