

Survey of Occupational Injuries and Illnesses
Internet Data Collection Facility

Initial Login


**Bureau of Labor Statistics
Internet Data Collection Facility**


[ADA Statement](#) | [Privacy Policy](#) | [Logout](#)

Internet Data Collection Facility (IDCF) Logon

[Test Your Browser](#)

Welcome to the Internet Data Collection Facility (IDCF). To report your survey data, you must logon with a valid password for the IDCF User ID that is included in your Bureau of Labor Statistics (BLS) survey documents.

User ID: 

Password:  [Forgot Password?](#)

Terms and Conditions of Use

WARNING! You are using an Official United States Government System, which may be used only for authorized purposes. Unauthorized modification of any information stored on this system may result in criminal prosecution. The Government may monitor and audit the usage of this system, and all persons are hereby notified that the use of this system constitutes consent to such monitoring and auditing. Unauthorized attempts to upload information and/or change information on these web sites are strictly prohibited and are subject to prosecution under the Computer Fraud and Abuse Act of 1986 and Title 18 U.S.C. Sec. 1001 and 1030.

Please read:
Due to security reasons, your session will time out after 30 minutes of system inactivity. You will need to logon to the website again to continue.

If you have questions or comments please complete and submit the [Help Request Form](#) 

Version: 10.0
URL: <https://idcf.bls.gov/WEB-INF/views/authentication/login.jsp>

Enter and confirm email

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Internet Data Collection Facility**

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Step 1 of 4: Check Email Address

Please enter and confirm your email address below. (* Required Field)

* Email 

* Confirm Email 

If you have questions or comments please complete and submit the [Help Request Form](#) 

Version: 10.0
URL: <https://idcf.bls.gov/WEB-INF/views/registration/checkemail.jsp>

Respondent Information

**Bureau of Labor Statistics
Internet Data Collection Facility**

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Step 2 of 4: Enter New User Information

Please complete the items below.

Name & Address of Person Completing this Form (* Required Field)

* Your Name

Your Job Title

* Your Company Name

* Address

* City

* State * Zip Code

* Telephone Ext Fax

ex. 1234567890 ex. 1234567890

[Continue](#)

If you have questions or comments please complete and submit the [Help Request Form](#)

Version: 10.0
URL: <https://idcf.bls.gov/WEB-INF/views/registration/confirmuser.jsp>

Create Password

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Step 3 of 4: Create a Permanent Password

The temporary password is no longer valid, please create a new password.

Password:

Confirm Password:

NOTE: Criteria met when ALL Green ✓'s appear

The password chosen MUST:

- ✗ Be between 8 and 12 characters in length
- ✗ Contain at least one (1) character from three (3) of the following categories:
 - UPPER CASE letter (A-Z)
 - lower case letter (a-z)
 - Digit (0-9)
 - Special Character !@#\$%^*-_=:/?[\]'{}~
- ✗ Both passwords must match

Select a Security Question:

Your Answer:



If you have questions or comments please complete and submit the [Help Request Form](#) 

Version: 10.0
URL: <https://idcf.bls.gov/WEB-INF/views/registration/createpermanentpassword.jsp>

Login Confirmation

**Bureau of Labor Statistics
Internet Data Collection Facility**

ADA Statement | Privacy Policy | Logout

Step 4 of 4: Confirmation Notice
Thank you for completing your registration.
Your permanent IDCF User ID appears below.

302888111094

In the future, you can use either this number or your email address along with your permanent password to log in.
Your User ID will also be emailed to you. To ensure that you receive email from the Bureau of Labor Statistics (BLS), add our domain "bls.gov" to your email Safe List.
Click on the "Continue" arrow to report your data.



If you have questions or comments please complete and submit the [Help Request Form](#) 
Version: 10.0
URL: <https://idcf.bls.gov/WEB-INF/views/registration/confirmation.jsp>

Select Survey
Update Respondent Info
Change Password

Update Respondent Information

Bureau of Labor Statistics-Internet Data Collection Facility(IDCF)Bureau of Labor Statistics - - Windows Internet Explorer pro

https://idcf.bls.gov/manage/respondentdata tk python colors

Bureau of Labor Statistics-Internet Data Collectio...

Bureau of Labor Statistics Internet Data Collection Facility

ADA Statement | Privacy Policy | Logout

Update Respondent Information

Please complete the items below.

Name & Address of Person Completing this Form (* Required Field)

* Your Name

Your Job Title

* Your Company Name

* Address

* City

* State * Zip Code

* Email

* Confirm Email

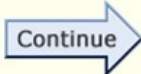
* Telephone Ext. Fax

ex. 1234567890 ex. 1234567890

Assign to another user

Check if the information above has been changed to assign this account to another user.

- NOTE: If you check this box, you will NO longer be the registered user, and you will NO longer have access to the system.
- The new user will be emailed the account number and a temporary password so he or she can begin reporting data to BLS.



If you have questions or comments please complete and submit the [Help Request Form](#)

Version: 10.0
URL: https://idcf.bls.gov/WEB-INF/views/manage/respondentdata.jsp

Help Request Form

Bureau of Labor Statistics Internet Data Collection Facility

Help Request Form

The Bureau of Labor Statistics (BLS) is committed to making its online information and services accessible to the widest possible audience.

Please complete the form below and click on the "Submit" button. You will be contacted by an IDCF help desk representative.

(* Required Field)

To receive a reply to your request, enter the following:

* Email Address:	<input type="text"/>
* First Name:	<input type="text"/>
* Last Name:	<input type="text"/>
* Phone Number:	<input type="text"/> - <input type="text"/> - <input type="text"/>

Enter your request information below:

* Nature of the Problem:	<input type="text"/>
* Problem Description:	<input type="text"/>

Please provide additional information below:

Which BLS Survey are you currently trying to report data for?	<input type="text"/>
Which State are you currently trying to report for?	<input type="text"/>
IDCF Account Number:	<input type="text"/>
Did you register using the email address above?	<input type="radio"/> Yes <input type="radio"/> No <input type="text"/>
	<input type="radio"/> Don't Know <input type="radio"/> Not Registered

Please note that your IP address will be captured automatically when you submit this form in order to help troubleshoot your issue.

Version: 1.0.1

Done

Trusted sites | Protected Mode: Off



105%

Survey Selection

Bureau of Labor Statistics Internet Data Collection Facility

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Welcome to the Internet Data Collection Facility

- o Please review your information listed below, and click the "Update" button to make any changes.
- o Select the appropriate survey and click the "Continue" arrow when you are ready to enter data.

Update Respondent Info

<input type="button" value="Update"/>	Alex Measure U.S. Bureau of Labor Statistics am...easur...e@gmail.com	2 Massachusetts Avenue Washington, DC 20212 202-691-6185
---------------------------------------	---	--

Please select a survey:

Maintenance activities may be conducted on Sundays from noon to 6:00 p.m. Eastern Time in order to keep the Internet Data Collection Facility (IDCF) at its peak performance and to cause as little disruption in service as possible to our customers. If the system is unavailable, please try back at a later time.

If you have questions or comments please complete and submit the [Help Request Form](#) 

Version: 10.0
URL: <https://idcf.bls.gov/WEB-INF/views/authentication/welcome.jsp>

General SOII Information

Bureau of Labor Statistics Survey of Occupational Injuries and Illnesses

[Help](#) | [Logout](#)

Dear Employer,

Please use this website to complete your Survey of Occupational Injuries and Illnesses (SOII).

Forms you will need:

1. The SOII Instructions form that was mailed to you.
2. OSHA forms ([Form 300, 300A, and 301](#)) in *Forms for Recording Work-Related Injuries and Illnesses*. Copies were mailed to you in late 2011.
 - o If the information requested is not recorded on your OSHA forms, please refer to other sources of information (including your Workers' Compensation records). Please note, [OSHA's recordkeeping rules](#) differ from Workers' Compensation's rules. You should complete this survey according to OSHA's rules.

What you need to do:


1. Complete the survey only for the establishment(s) listed on the front cover of your instruction sheet under *'Report for this Location.'*
2. Report data for more than one establishment by using the *'Add New Establishment ID(s) to Account'* function on the next page.

If you have questions about completing this survey, please call the number listed on the front upper right corner of your instruction sheet under *'For Help:'*. For website technical help only, go to the helpdesk link at the bottom of the page.

See our [Frequently Asked Questions](#) to familiarize yourself with features of this site.

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.

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, D.C. 20212. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. Form Approved OMB No. 1220-0045

 Continue

If you have questions or comments please send e-mail to: osh.helpdesk@bls.gov
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials
Version: 11.0.3
URL: <https://idcfosh.bls.gov/OSH/index.jsp>

More than one survey

Survey of Occupational Injuries and Illnesses

Help | Logout

Have you received more than one survey to report for 2012?

Yes
 No



If you have questions or comments please send e-mail to: osh.helpdesk@bls.gov
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials
Version: 11.0.3
URL: <https://idcfosh.bls.gov/OSH/content/additionalForms.jsp>

Add new establishment ID's

Survey of Occupational Injuries and Illnesses

Help | Logout

Add New Establishment ID(s) to Account

1. [Click here to see the Establishment ID\(s\) already attached to your account.](#)
2. Enter the number of **additional** Establishment ID(s) for which you need to report.
3. Enter the **additional** Establishment ID(s) below.

- -
 - -

ALABAMA DEPT OF LABOR
PO BOX 123456
MONTGOMERY, AL 12345

Establishment ID:
01-123456789-1

Report For:

PRIMARY COMPANY NAME
(SECONDARY COMPANY NAME)
ADDRESS LINE 1
ADDRESS LINE 2
CITY, STATE ZIP-PLUS+4

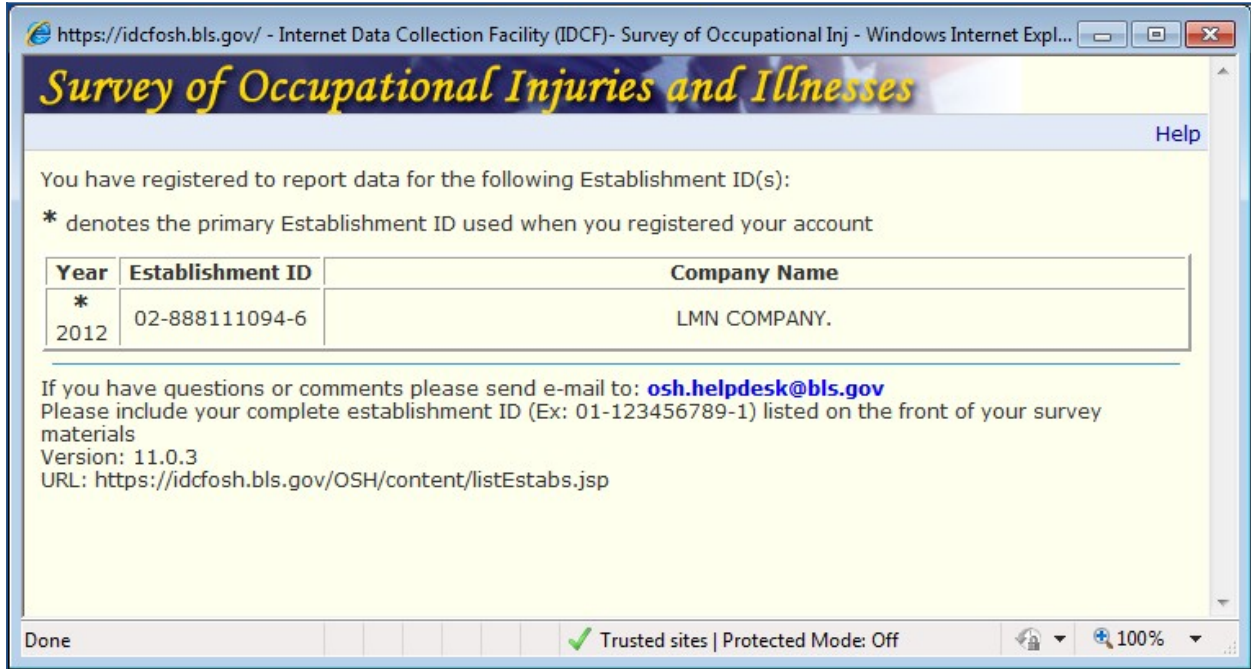
Example



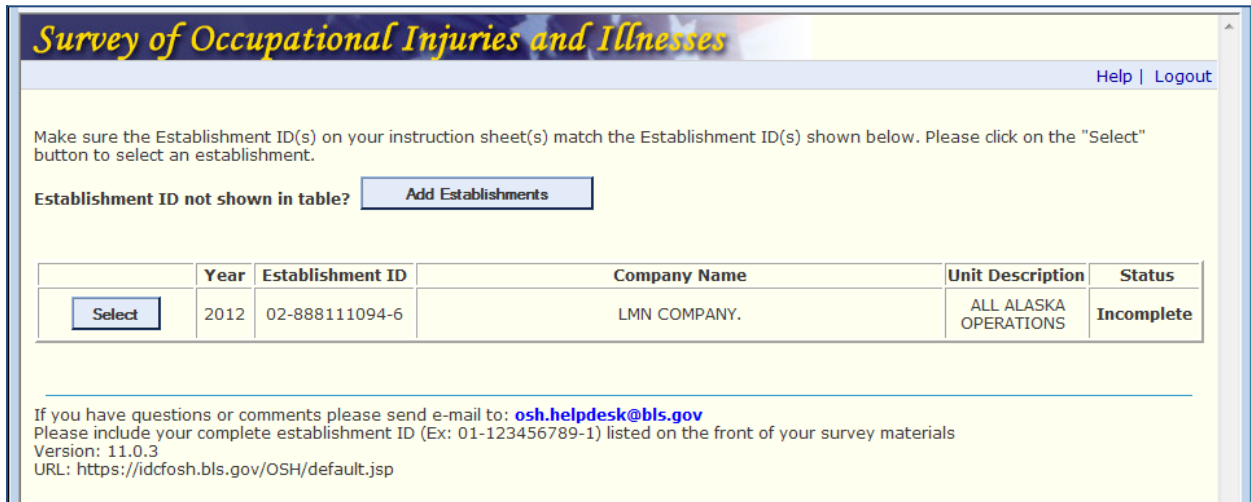
Your Establishment ID is located here above your mailing address.

If you have questions or comments please send e-mail to: osh.helpdesk@bls.gov
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials
Version: 11.0.3
URL: <https://idcfosh.bls.gov/OSH/content/lDbCreate.jsp>

Establishment ID's attached to account



Select Establishment



Section 1: Establishment Information

Survey of Occupational Injuries and Illnesses

[Update Respondent Information](#) | [Help](#) | [Logout](#)



Section 1. Establishment Information

Establishment ID: **02-888111094-6** [Add comments](#)

Please click on the "Update" button to revise establishment location information, if necessary.

Update Establishment Location Information

Update

ABC COMPANY. 1234 MAIN ST
ALL ALASKA OPERATIONSSnowbridge AK 99555- 1234

- Copy the information from your completed Calendar Year 2012 *Summary of Work Related Injuries and Illnesses (OSHA Form 300A)* into the spaces below.
- Use the *help links* for Items (1) and (2) if annual average number of employees and total hours worked are not available from your OSHA 300A.

1. Enter the annual average number of employees for 2012.

[Help me calculate this](#)

2. Enter the total hours worked by all employees for 2012.

[Help me calculate this](#)

Average Hours Worked per Employee

3. Check any conditions that might have affected your annual average number of employees or total hours worked during 2012:

- | | |
|---|---|
| <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="text"/> |
| <input type="checkbox"/> Natural disaster or adverse weather conditions | <input type="checkbox"/> Nothing unusual happened to affect our employment or hours figures |

4. [Did you have ANY work-related injuries or illnesses during 2012?](#)

- Yes
 No

Save & Continue

If you have questions or comments please send e-mail to: osh.helpdesk@bls.gov
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials
Version: 11.0.3
URL: <https://idcfosh.bls.gov/OSH/content/part1a.jsp>

Update Establishment Information

The screenshot shows a web browser window with the URL <https://idcfosh.bls.gov/?ldbNumber=888111094&page=1a>. The page title is "Survey of Occupational Injuries and Illnesses" and it includes a "Help" link. The main heading is "Establishment Location Information".

Please review and update your establishment location information. Click on the 'Submit' button to save your data.
(* Required Field)

* Company Name

* Address

* City

* State * Zip Code

Unit Description

If you have questions or comments please send e-mail to: osh.helpdesk@bls.gov
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials
Version: 11.0.3
URL: <https://idcfosh.bls.gov/OSH/content/address.jsp>

The browser's status bar at the bottom shows "Trusted sites | Protected Mode: Off" and a zoom level of 90%.

Worksheet to Estimate Annual Average Number of Employees

https://idcfosh.bls.gov/?surveyYear=2012 - Survey of Occupational Injuries an... Help

Survey of Occupational Injuries and Illnesses

Worksheet for Estimating Annual Average Number of Employees

Step 1. Enter the number of pay periods during 2012.

Step 2.

If more than one establishment is listed on the front of your instruction sheet under 'Report for', add the total number of employees from all locations and enter that number in the spaces below.

- Enter the number of employees that your establishment paid in every pay period during 2012. We will calculate the total for you.
- Count all employees: [full-time](#), [part-time](#), [temporary](#), [seasonal](#), salaried, and hourly.

In this pay period	You paid this many employees
1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

If you have questions or comments please send e-mail to: osh.helpdesk@bls.gov
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials
Version: 11.0.3
URL: <https://idcfosh.bls.gov/OSH/content/empWorksheet.jsp>

Trusted sites | Protected Mode: Off 90%

Worksheet to Estimate Total Hours Worked

https://idcfosh.bls.gov/?surveyYear=2012 - Survey of Occupational Injuries a... [-] [Max] [X]

Survey of Occupational Injuries and Illnesses

Help

Worksheet for Estimating Total Hours Worked by All Employees

A. Hours worked by full-time employees:

Enter the number of full-time employees

Enter the number of hours generally worked by a full-time employee **for a year**


Enter the number of overtime hours worked by full-time employees

Total hours for full-time employees in 2012

B. Hours worked by other employees: (including part-time, temporary and seasonal)

Enter the number of hours worked in 2012 by all non-full-time employees including part-time, temporary, and seasonal

C. Total hours worked by all employees:

 Continue

Trusted sites | Protected Mode: Off 🔒 90% 🔍

Section 1: Error Messages

Survey of Occupational Injuries and Illnesses

[Update Respondent Information](#) | [Help](#) | [Logout](#)

- 1**
Establishment
Information
(Section 1)
- 2**
Injuries &
Illnesses
(Section 2)
- 3**
Cases
(Section 3)
- 4**
Data
Review

Section 1. Establishment Information

Please correct the error(s) listed below:

- You must enter the Average Number of Employees
- You must enter the Total Hours Worked

Establishment ID: **02-888111094-6** [Add comments](#)

Please click on the "Update" button to revise establishment location information, if necessary.

Update Establishment Location Information

Update

ABC COMPANY. 1234 MAIN ST
ALL ALASKA OPERATIONS Snowbridge, AK 99555 - 1234

- Copy the information from your completed Calendar Year 2012 *Summary of Work Related Injuries and Illnesses (OSHA Form 300A)* into the spaces below.
- Use the *help links* for Items (1) and (2) if annual average number of employees and total hours worked are not available from your OSHA 300A.

1. Enter the annual average number of employees for 2012.

[Help me calculate this](#)

2. Enter the total hours worked by all employees for 2012.

[Help me calculate this](#)

Average Hours Worked per Employee

3. Check any conditions that might have affected your annual average number of employees or total hours worked during 2012:

- | | |
|---|---|
| <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="text"/> |
| <input type="checkbox"/> Natural disaster or adverse weather conditions | <input type="checkbox"/> Nothing unusual happened to affect our employment or hours figures |

4. [Did you have ANY work-related injuries or illnesses during 2012?](#)

- Yes
 No (NOTE: work-related injuries or illnesses were previously entered.)

Save & Continue

If you have questions or comments please send e-mail to: osh.helpdesk@bls.gov
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials
Version: 11.0.3
URL: <https://idcfosh.bls.gov/OSH/content/part1a.jsp>


Section 2: Summary of Work-Related Injuries and Illnesses, 2012

Survey of Occupational Injuries and Illnesses

[Update Respondent Information](#) | [Help](#) | [Logout](#)

- 1**
Establishment
Information
(Section 1)
- 2**
Injuries &
Illnesses
(Section 2)
- 3**
Cases
(Section 3)
- 4**
Data
Review

Section 2. Summary of Work-Related Injuries and Illnesses, 2012

Establishment ID: **02-888111094-6** [Add comments](#) 

Refer to the OSHA *Forms for Recording Work-Related Injuries and Illnesses* (Forms 300 and 300A) for this location.

Instructions

1. Complete this survey only for the location(s) listed under 'Report for' on the front of your survey instruction sheet.
2. If more than one establishment is listed under 'Report for' add up the numbers across all establishments and enter the total in the spaces below.
3. Enter numbers only, omitting letters, symbols, decimals, and commas.
4. If any total is zero on your OSHA Form 300A, enter "0" in that total's space below.
5. 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](#)

(G)

[Total number of cases with days away from work](#)

(H)

[Total number of cases with job transfer or restriction](#)

(I)

[Total number of other recordable cases](#)

(J)

Number of Days

[Total number of days away from work](#)

(K)

[Total number of days of job transfer or restriction](#)

(L)

Injury and Illness Types

Total number of...
(M)

1. Injuries


2. Skin disorders

3. Respiratory conditions

4. Poisonings

5. Hearing loss

6. All other illnesses

Save & Continue 

If you have questions or comments please send e-mail to: osh.helpdesk@bls.gov
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials
Version: 11.0.3
URL: <https://idcfosh.bls.gov/OSH/content/part1b.jsp>

Section 2 Error Message

Survey of Occupational Injuries and Illnesses

[Update Respondent Information](#) | [Help](#) | [Logout](#)

- 1**
Establishment Information
(Section 1)
- 2**
Injuries & Illnesses
(Section 2)
- 3**
Cases
(Section 3)
- 4**
Data Review

Section 2. Summary of Work-Related Injuries and Illnesses, 2012

Please correct the error(s) listed below:

- Your Number of Cases (columns G-J) should equal the Number of Injury and Illness Types (columns M1-M6)

Establishment ID: **02-88811094-6** [Add comments](#)

Refer to the OSHA Forms for Recording Work-Related Injuries and Illnesses (Forms 300 and 300A) for this location.

Instructions

1. Complete this survey only for the location(s) listed under 'Report for' on the front of your survey instruction sheet.
2. If more than one establishment is listed under 'Report for' add up the numbers across all establishments and enter the total in the spaces below.
3. Enter numbers only, omitting letters, symbols, decimals, and commas.
4. If any total is zero on your OSHA Form 300A, enter "0" in that total's space below.
5. 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](#)

(G)

[Total number of cases with days away from work](#)

(H)

[Total number of cases with job transfer or restriction](#)

(I)

[Total number of other recordable cases](#)

(J)

Number of Days

[Total number of days away from work](#)

(K)

[Total number of days of job transfer or restriction](#)

(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

Save & Continue 

If you have questions or comments please send e-mail to: osh.helpdesk@bls.gov
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials

Section 3: Cases with Days Away from Work

Survey of Occupational Injuries and Illnesses

[Update Respondent Information](#) | [Help](#) | [Logout](#)

- 1 Establishment Information (Section 1)
- 2 Injuries & Illnesses (Section 2)
- 3 Cases (Section 3)**
- 4 Data Review

Section 3. Cases with Days Away from Work

Establishment ID: **02-888111094-6**

In Section 2 you reported:

1 case(s) with days away from work (Column H).

Enter data for cases with days away from work.

Continue to Section 4

If you have questions or comments please send e-mail to: osh.helpdesk@bls.gov
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials
Version: 11.0.3
URL: https://idcfosh.bls.gov/OSH/content/cases_summary.jsp

Enter Case Details (1 of 2)

Survey of Occupational Injuries and Illnesses

[Update Respondent Information](#) | [Help](#) | [Logout](#)

Enter Information about a Case with Days Away from Work

Establishment ID: **02-888111094-6**

To complete the information below, you will need:

- Your completed copy of your OSHA Form 300 for 2012.
- Your completed copies of supplementary documents about the case, such as workers' compensation report, an accident report, an insurance form, or the *Injury and Illness Incident Report*, OSHA Form 301.

Tell us about a 2012 work-related injury or illness ONLY if it resulted in days away from work.

Employee's name

(column B)

Job title

(column C)

[Date of injury or onset of illness](#)

(column D)

MM DD YYYY

[Number of days away from work](#)

(column K)

[Number of days of job transfer or restriction](#)

(column L)

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

- | | |
|--|--|
| <input type="radio"/> Office, professional, business, or management staff | <input type="radio"/> Healthcare |
| <input type="radio"/> Sales | <input type="radio"/> Delivery or driving |
| <input type="radio"/> Product assembly, product manufacture | <input type="radio"/> Food Service |
| <input type="radio"/> Repair, installation or service of machines, equipment | <input type="radio"/> Cleaning, maintenance of building, grounds |
| <input type="radio"/> Construction | <input type="radio"/> Material handling (e.g. stocking, loading/unloading, moving, etc.) |
| <input type="radio"/> Other: <input type="text"/> | <input type="radio"/> 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

3. Employee's age: OR date of birth: MM DD YYYY

4. Employee's date hired: MM DD YYYY
OR select 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:

Enter Case Details (2 of 2)

5. Employee's gender:
 Male
 Female

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 (optional): Before During After work shift

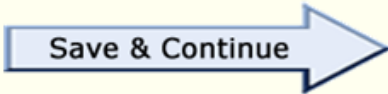
10. What was the employee doing just before the incident occurred?
Describe the activity as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry." (maximum entry of 250 characters)

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." (maximum entry of 250 characters)

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." (maximum entry of 250 characters)

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. (maximum entry of 250 characters)

Case Comments:
Enter additional case information here (optional).



Enter Case Details Error Messages

Survey of Occupational Injuries and Illnesses

[Update Respondent Information](#) | [Help](#) | [Logout](#)

Enter Information about a Case with Days Away from Work

Please correct the error(s) listed below:

- You must enter the Employee's Name
- You must enter the Job Title
- You must enter the Date of Injury or Onset of Illness
- You must enter the Number of Days Away from Work

Establishment ID: 02-888111094-6

To complete the information below, you will need:

- Your completed copy of your OSHA Form 300 for 2012.
- Your completed copies of supplementary documents about the case, such as workers' compensation report, an accident report, an insurance form, or the *Injury and Illness Incident Report*, OSHA Form 301.

Tell us about a 2012 work-related injury or illness ONLY if it resulted in days away from work.

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)

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

- | | |
|--|--|
| <input type="radio"/> Office, professional, business, or management staff | <input type="radio"/> Healthcare |
| <input type="radio"/> Sales | <input type="radio"/> Delivery or driving |
| <input type="radio"/> Product assembly, product manufacture | <input type="radio"/> Food Service |
| <input type="radio"/> Repair, installation or service of machines, equipment | <input type="radio"/> Cleaning, maintenance of building, grounds |
| <input type="radio"/> Construction | <input type="radio"/> Material handling (e.g. stocking, loading/unloading, moving, etc.) |
| <input type="radio"/> Other: <input type="text"/> | <input type="radio"/> 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

3. Employee's age: OR date of birth:

4. Employee's date hired:
OR select length of service at establishment when incident occurred:
 Less than 3 months

Section 3: With one added case

Survey of Occupational Injuries and Illnesses

Update Respondent Information | Help | Logout

1 Establishment Information (Section 1) 2 Injuries & Illnesses (Section 2) **3 Cases (Section 3)** 4 Data Review

Section 3. Cases with Days Away from Work

Establishment ID: **02-888111094-6**

In Section 2 you reported:

1 case(s) with days away from work (Column H).

Enter data for cases with days away from work.

You may **Update** or **Delete** previously entered data below:

	Employee's Name	Job Title	Date of Injury	Days		
				Away from Work	of Restriction	
<input type="button" value="Update"/>	John Doe	Nurse	02/04/2012	3	1	<input type="button" value="Delete"/>

Continue to Section 4

If you have questions or comments please send e-mail to: osh.helpdesk@bls.gov
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials
Version: 11.0.3
URL: https://idcfosh.bls.gov/OSH/content/cases_summary.jsp

Section 4: Review (1 of 2)

Survey of Occupational Injuries and Illnesses

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1

Establishment Information
(Section 1)

2

Injuries & Illnesses
(Section 2)

3

Cases
(Section 3)

4

Data Review

Review your data

You can click on the buttons above to return to a section to correct an entry.

Establishment ID: 02-888111094-6

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
0	1	0	0
(G)	(H)	(I)	(J)

Number of Days	
Total number of days away from work	Total number of days of job transfer or restriction
0	0
(K)	(L)

Injury and Illness Types			
Total number of... (M)			
(1) Injuries	1	(4) Poisonings	0
(2) Skin disorders	0	(5) Hearing loss	0
(3) Respiratory conditions	0	(6) All other illnesses	0

Establishment Information

Your establishment name: ABC COMPANY.

Street: 1234 MAIN ST

City: Snowbridge State: AK ZIP: 99555

Employment information

Annual average number of employees: 5

Total hours worked by all employees last year: 10000

Establishment Comments - Section 1 & Section 2

Establishment ID: 02-888111094-6

- No comments to report.

Section 3 - Cases with Days Away from Work

Section 4: Review (2 of 2)

Section 3 - Cases with Days Away from Work

Establishment ID: 02-888111094-6

Employee Name: **John Doe**
Job Title: **Nurse**
Date of Injury or onset of illness: **02/04/2012**
Number of days away from work: **3**
Number of days of job transfer or restriction: **1**

1. Type of Job or Work:
2. Employee's race or ethnic background:
3. Employee's age:
Employee's date of birth:
4. Employee's date hired:
Employee's length of service when incident occurred:
5. Employee's gender:
6. Treated in emergency room?
7. Hospitalized overnight as in-patient
8. Time employee began work:
9. Time of event:
10. What was the employee doing before the incident?
11. What happened?
12. What was the injury or illness?
13. What object or substance directly harmed the employee?

Case Comments:

Print

Print a copy of this form for your records.

Submit

Click the Submit button to send your data to BLS. You will receive a confirmation on the next page.

Keep the confirmation

Keep a copy of the confirmation for your records.

If you have questions or comments please send e-mail to: osh.helpdesk@bls.gov
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials
Version: 11.0.3
URL: https://idcfosh.bls.gov/OSH/content/summary_review.jsp

Confirmation

Survey of Occupational Injuries and Illnesses

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Thank you for Reporting!
Establishment ID: **02-888111094-6**

Your data have been received by BLS on 04/30/2013 at 03:28 PM. Thank you for helping us collect accurate information and for helping to make America's workplaces safer and healthier.

If you are included in the 2013 survey, the survey materials will be mailed to you in early January 2014. If you have any questions about the survey or your participation in it, please contact us at the email address below.

[Enter data for another establishment](#)

[Return to SOII Home Page](#)

[Return to IDCF Home Page](#)

If you have questions or comments please send e-mail to: osh.helpdesk@bls.gov
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials
Version: 11.0.3
URL: <https://idcfosh.bls.gov/OSH/content/thankyou.jsp>