

**Bureau of Labor Statistics
Census of Fatal
Occupational Injuries Report**

U.S. Department of Labor



OMB No. 1220-0133

This report is authorized by Public Law 91-596. 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.

ID	Public Burden Statement: Your voluntary cooperation is needed to make the results of this study comprehensive, accurate, and timely. The Bureau estimates that it will take from 10 to 30 minutes to complete this form, with an average of 20 minutes, including time for gathering the information needed and completing the form. If you have any comments regarding this estimate or any other aspect of this data collection, including suggestions for reducing this burden, you may send them to the Bureau of Labor Statistics, CFOI Program, 2 Massachusetts Avenue, NE, Room 3180, Washington, DC 20212-0001. Do not send the completed form to this address. You do not have to complete this form if it does not display a currently valid OMB Control Number.
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Return to:

For assistance call:

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

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

SECTION I. DECEASED WORKER AND EMPLOYER

NAME: _____

1. **Legal name:** *(Please print):* _____
(Last) *(First)* *(Middle)*

2. **Social Security Number:** _____

3. **Direct employer at the time of the incident (company that paid deceased's wages):**

(Company name)

(Street address)

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

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

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

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

8. What time did the incident occur? Check only ONE: AM PM

9. What time did the deceased's workday begin on the day the incident occurred? Check only ONE: AM PM

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

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

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

- a. Include information about how the injury/illness occurred.
- b. Identify any equipment, objects, or substances involved in the incident and describe how they were involved. (Please use additional pages if more space is needed.)

SECTION IV. RESPONDENT IDENTIFICATION

Please provide the following information:

1. Your name: _____

2. Your job title: _____

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

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