IDCF Log in screen

BUREAU OF LABOR STATISTICS
Internet Data Collection Facility

ADA Statement | Privacy Policy

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: [User ID]

Password: [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.

I Accept

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: 10.1.1

Step 1 of 4: Check Email Address

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

* Email: [　　　　　　　　　] ⊕

* Confirm Email: [　　　　　　　　　] ⊕

[Continue]

If you have questions or comments please complete and submit the Help Request Form ↗ | Version: 10.1.1

Step 2 of 4: Enter New User Information

Please complete the items below.
Name & Address of Person Completing this Form (***** Required Field)

* Your Name:	Gina
Your Job Title:	Tester
* Your Company Name:	Test Company
* Address:	12 Test Way
* City:	Nashville
* State:	TN
* Zip Code:	22334	Zip Ext
* Telephone:	3435554444	Ext
Fax:	

Continue

If you have questions or comments please complete and submit the Help Request Form | Version: 10.1.1

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ADA Statement | Privacy Policy | Logout

Step 3 of 4: Create a Permanent Password

The temporary password is no longer valid, please create a new password.

Password: ●●●●●●●●

Confirm Password: ●●●●●●●●

Continue   Password Information

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

If you have questions or comments please complete and submit the Help Request Form ✉ | Version: 10.1.1

Step 4 of 4: Confirmation Notice

Thank you for completing your registration.

Your permanent IDCF User ID appears below.

302140264710

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" button to report your data.

Please do not click on the "Back" button, your registration process has been completed.

Registration Confirmation

Continue

If you have questions or comments please complete and submit the Help Request Form » | Version: 10.1.1

Welcome to the Internet Data Collection Facility

Select Survey
Update Respondent Info
Change Password

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

Respondent Information

Update		
	Gina tester21@testing.com 343-555-4444	**Test Company** 12 Test Way Nashville TN 22334

Please select a survey: Survey of Occupational Injuries and Illnesses ▾

Continue

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: 10.1.1

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 2014.

   ◦ 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 record keeping 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 Establishment'* button 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.

Continue →

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

If you have questions or comments please complete and submit the Help Request Form | Version: 11.3
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials

Contact Preference

If your establishment(s) is selected for a **future** Survey of Occupational Injuries and Illnesses, how would you like to be notified?

☐ Email

We will email instructions to the following email address for completing the Survey of Occupational Injuries and Illnesses.

[tester21@testing.com]

☐ Postal mail

We will mail instructions via U.S. Postal Service to your establishment(s) for completing the Survey of Occupational Injuries and Illnesses.

[Continue ➜]

If you have questions or comments please complete and submit the Help Request Form | Version: 11.3
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials

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Contact Preference

If your establishment(s) is selected for a **future** Survey of Occupational Injuries and Illnesses, how would you like to be notified?

☑ Email

We will email instructions to the following email address for completing the Survey of Occupational Injuries and Illnesses.

[tester21@testing.com]

☐ Postal mail

We will mail instructions via U.S. Postal Service to your establishment(s) for completing the Survey of Occupational Injuries and Illnesses.

Continue ➡

If you have questions or comments please complete and submit the Help Request Form | Version: 11.3
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials

BUREAU OF LABOR STATISTICS
Survey of Occupational Injuries and Illnesses

Make sure the Establishment ID(s) on your instruction sheet(s) match the Establishment ID(s) shown below.

Establishment ID not shown in table?   [Add Establishment]

Please click on the "Select" button to select an establishment and begin reporting data.

	Year	Establishment ID	Company Name	Unit Description	Status	
Select	2015	20-140264710-1	Testing company	120 W KANSAS EMP ONLY	Incomplete	Remove

If you have questions or comments please complete and submit the Help Request Form | Version: 11.3
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials

BUREAU OF LABOR STATISTICS
Survey of Occupational Injuries and Illnesses

Update Respondent Information | Help | Logout

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

Section 1. Establishment Information

Update Establishment Location Information

Establishment ID: **20-140264710-1**
Add comments

Update	Testing company ATTN MANAGER 120 W KANSAS EMP ONLY	120 W KANSAS Nashville, TN 33333 -

- Complete this survey only for the location(s) listed under *'Report for'* on the front of your survey instruction sheet.
- 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.
- Copy the information from your completed Calendar Year 2015 *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 2015.

   [50]   Help me calculate this

2. Enter the total hours worked by all employees for 2015.

   [100000]   Help me calculate this

   [2000]   Annual average hours worked per employee

3. Check any conditions that might have affected your annual average number of employees or total hours worked during 2015:

   ☐ Strike or lockout
   ☐ Shutdown or layoff
   ☐ Seasonal work

   ☐ Shorter work schedules or fewer pay periods than usual
   ☐ Longer work schedules or more pay periods than usual
   ☑ Nothing unusual happened to affect our employment or hours figures

   ☐ Natural disaster or adverse weather conditions

   ☐ Other reason: [_____]

4. Did you have ANY work-related injuries or illnesses during 2015?
   ⦿ Yes
   ◯ No

[Save & Continue ➡]

If you have questions or comments please complete and submit the Help Request Form | Version: 11.3
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials

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From screen above, or any screen within the survey, users can click on the "Help Request Form" link on the bottom of the page to send a question to the helpdesk. This form is shown below. This year we added a Salutation drop down so that our helpdesk staff can address users properly:

After submitting the help request, the user will return to Section 1 and press "Save and Continue" to proceed through the survey...

Update Respondent Information | Help | Logout

| 1 | Establishment Information (Section 1) | 2 | Injuries and Illnesses (Section 2) | 3 | Cases (Section 3) | 4 | Data Review (Section 4) |

Section 2. Summary of Work-Related Injuries and Illnesses, 2015

Establishment ID: **20-140264710-1**
Add comments

Instructions

1. Refer to the OSHA *Forms for Recording Work-Related Injuries and Illnesses* (Forms 300 and 300A) for this location.
2. If any total is zero on your OSHA Form 300A, enter "0" in that total's space below.
3. 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).
4. When counting the days away from work or job transfer or restriction, do not include the day the injury or illness occurred.

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

Number of Days		
Total number of days away from work		Total number of days of job transfer or restriction
13		5
(K)		(L)

Injury and Illness Types

Total number of...

13

(M)

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

Save & Continue ➜

If you have questions or comments please complete and submit the Help Request Form | Version: 11.3
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials

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Update Respondent Information | Help | Logout

| 1 | Establishment Information (Section 1) | 2 | Injuries and Illnesses (Section 2) | 3 | Cases (Section 3) | 4 | Data Review (Section 4) |

Section 3. Cases with Days Away from Work

Establishment ID: **20-140264710-1**

In Section 2 you reported:

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

Enter data for cases with days away from work in the table below.

Employee's Name	Job Title	Date of Injury	Days	
			Away from Work	of Restriction
Enter Case 1				

Enter Case 1

Enter Additional Case

Continue ➔

If you have questions or comments please complete and submit the Help Request Form | Version: 11.3
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials

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Enter Information about a Case with Days Away from Work

To complete the information below, you will need: Establishment ID: **20-140264710-1**

- Your completed copy of your OSHA Form 300 for 2015.
- 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 2015 work-related injury or illness ONLY if it resulted in days away from work.

Employee's name (column B)	John
Job title (column C)	Janitor
Date of injury or onset of illness (column D)	07-Jul 03 2015
Number of days away from work (column K)	13
Number of days of job transfer or restriction (column L)	5

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

   ☐ Office, professional, business, or management staff   ☐ Repair, installation or service of machines, equipment

   ☐ Healthcare   ☑ Cleaning, maintenance of building, grounds

   ☐ Sales   ☐ Construction

   ☐ Delivery or driving   ☐ Material handling (e.g. stocking, loading/unloading, moving, etc.)

   ☐ Product assembly, product manufacture   ☐ Farming

   ☐ Food Service   ☐ Other: _____

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: [34]

   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:
   - ☑ Male
   - ☐ Female

6. Was employee treated in an emergency room?
   - ☐ Yes
   - ☑ No

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7. Was employee hospitalized overnight as an in-patient?
   ☐ Yes
   ☑ No

8. Time employee began work: [5 am ▼] [01 ▼]

9. Time of event: [10 am ▼] [06 ▼]
   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."* (maximum entry of 1500 characters)

    buffing floors

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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 1500 characters)

employee slipped

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 1500 characters)

back strain and contusion to the elbow

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 1500 characters)

concrete floor

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

Save & Continue ➜

If you have questions or comments please complete and submit the Help Request Form | Version: 11.3
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials

Update Respondent Information | Help | Logout

| 1 | Establishment Information (Section 1) | 2 | Injuries and Illnesses (Section 2) | 3 | Cases (Section 3) | 4 | Data Review (Section 4) |

Section 3. Cases with Days Away from Work

Establishment ID: **20-140264710-1**

In Section 2 you reported:

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

Enter data for cases with days away from work in the table below.

| | Employee's Name | Job Title | Date of Injury | Days | | |
				Away from Work	of Restriction	
Edit	John	Janitor	07/03/2015	13	5	Delete

Enter Additional Case

Continue ➜

If you have questions or comments please complete and submit the Help Request Form | Version: 11.3
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials

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BUREAU OF LABOR STATISTICS
Survey of Occupational Injuries and Illnesses

Help | Logout

| 1 | Establishment Information (Section 1) | 2 | Injuries and Illnesses (Section 2) | 3 | Cases (Section 3) | 4 | Data Review (Section 4) |

Review your data

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

Establishment ID: **20-140264710-1**

Section 1 - Establishment Information

Establishment Address

Testing company
120 W KANSAS

Nashville , TN 33333

Employment Information

- Annual average number of employees: 50
- Total hours worked by all employees last year: 100000

Section 2 - Summary of Work-Related Injuries and Illnesses

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

Number of Days			
Total number of days away from work		Total number of days of job transfer or restriction	
13		5	
(K)		(L)	

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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 _____1_____   (6) All other illnesses _____0_____

Establishment Comments - Section 1 & Section 2

- No comments to report.

Section 3 - Cases with Days Away from Work

Case 1

Employee Name: **John**
Job Title: **Janitor**
Date of Injury or onset of illness: **07/03/2015**
Number of days away from work: **13**
Number of days of job transfer or restriction: **5**
1. Type of Job or Work: **Cleaning, maintenance of building, grounds**
2. Employee's race or ethnic background:
   - **Not available**
3. Employee's age: **34**
   Employee's date of birth:
4. Employee's date hired:
   Length of service: **From 1 to 5 years**
5. Employee's gender: **Male**
6. Treated in emergency room? **No**
7. Hospitalized overnight as in-patient **No**
8. Time employee began work: **5:01 AM**
9. Time of event: **10:06 AM**
   Event Occurred: **During** work shift
10. What was the employee doing before the incident?
    buffing floors
11. What happened?
    employee slipped
12. What was the injury or illness?
    back strain and contusion to the elbow
13. What object or substance directly harmed the employee?
    concrete floor

Case Comments:

Click the Submit button to send your data to BLS.

[Submit]

If you have questions or comments please complete and submit the Help Request Form | Version: 11.3
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials

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Thank you for Reporting!

Enter data for another establishment

Return to IDCF Home Page

Return to SOII Home Page

Establishment ID: **20-140264710-1**

Your data were received by BLS on 11/06/2015 at 09:37 AM EST.
You will receive a confirmation e-mail at the address you used to register this account. Keep a copy of the confirmation for your records.

If you are included in the 2016 survey, the survey materials will be mailed to you in early January 2017.

Print Submission

If you have questions or comments please complete and submit the Help Request Form | Version: 11.3
Please include your complete establishment ID (Ex: 01-123456789-1) listed on the front of your survey materials

PDF fillable form

To aid users who wish to use the Adobe fillable form, troubleshooting instructions were added to the email that accompanies the PDF fillable form. The email text is copied below:

Thank you for contacting the Bureau of Labor Statistics to request an electronic version of the Survey of Occupational Injuries and Illnesses. A fillable PDF of the survey form is attached to this e-mail.

PLEASE NOTE: We have designed this survey to ensure that you do not have to report more than approximately 15 cases with days away from work.
If you have significantly more than 15 cases, please call us at 404-893-1934 for assistance.

1. **Save the attached form to your computer and open it using Adobe Reader (version 8 or higher). If you do not have Adobe Reader, you can download it for free from:**
   http://get.adobe.com/reader/

   Note: Please make sure the form opens up in Adobe Reader and not in Preview.

2. Enter your establishment's identifying information (establishment ID, address, and contact information), and then enter your establishment's injury and illness data.

   - You may use the TAB key and the mouse to navigate through the fields on the form.
   - You do not need to complete the survey in one sitting.
   - You can save the form and come back later to complete entering your information.

3. When all of your data is entered, please save the form on your computer and print a copy for your records in case we need to contact you.

4. When you have completed the survey, send the form to the Bureau of Labor Statistics by pressing the 'Submit' button on the last page of the form.

If you are having trouble opening the PDF fillable form, it is possible that you have an older version of Adobe that is not compatible with our form. You may be able to fix the issue by doing the following:

1. Save the PDF form attached to this email to your desktop.
2. Download the latest Adobe Reader installer from http://get.adobe.com/reader/.
3. Run the Adobe Reader installer and follow the prompts.

4. Once installation is complete, manually launch Adobe Reader by clicking the Adobe Reader icon that was created.
5. From within Adobe Reader, go to File → Open and open the PDF form from your desktop.

Make sure to follow step #4 to use the new version of Adobe Reader to open the document, otherwise your computer may try to use the previous version of Adobe Reader which is not compatible with our form.

If you have any questions, you can contact us at osh.helpdesk@bls.gov.

U.S. Bureau of Labor Statistics Statement to Respondent on the Use of Electronic Data Transmission

As a participant in a U.S. Bureau of Labor Statistics (BLS) statistical survey, you should be aware that use of electronic transmittal methods in reporting data involves certain inherent risks to the confidentiality of those data. Further, you should be aware that responsible electronic transmittal practices employed by the BLS cannot completely eliminate those risks.

The BLS is committed to the responsible treatment of the data you report and will take appropriate steps within their ability to protect the confidentiality of those data.

Please do not reply to this message as it is from an automated mailbox. Any replies to this e-mail will not be responded to or forwarded. This service is used for outgoing e-mails only and cannot respond to inquiries.

U.S. Department of Labor
Bureau of Labor Statistics

Survey of Occupational Injuries and Illnesses, 2015

Refer to the 2015 SOII survey instructions you received in the mail.

Enter your 12-digit Establishment ID and e-mail.

Your Establishment ID can be found on the front left side of the survey instructions you received and will be similar to this:

*Establishment ID: ☐ - ☐ - ☐

*E-Mail: ☐

*Required to use this form.

STATE DEPT OF LABOR
STREET ADDRESS
CITY, STATE ZIP

2015 Establishment ID:
00-000000000-0

Report For: Example

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

|||||||||||||||||||||||||||||||||

Enter your company name and mailing address.

Company Name: ☐
Street Address 1: ☐
Street Address 2: ☐
City: ☐
State: ☐
ZIP: ☐ - ☐

Enter your contact information.

Name: ☐
Title: ☐
Phone: ☐ - ☐ - ☐

Section 1: Establishment Information

Instructions: Using your completed Calendar Year 2015 *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 (1) and (2) below, provide estimates by following the instructions on the next page.

1. Enter the annual average number of employees for 2015 (numbers only).

2. Enter the total hours worked by all employees for 2015 (numbers only).

3. Check any conditions that might have affected your answers to questions 1 and 2 above during 2015.

   ☐ Strike or lockout   ☐ Shorter work schedules or fewer pay periods than usual

   ☐ Shutdown or layoff   ☐ Longer work schedules or more pay periods than usual

   ☐ Seasonal work   ☐ Other reason:

   ☐ Natural disaster or adverse weather conditions   ☐ Nothing unusual happened to affect our employment or hours figures

4. Did you have ANY work-related injuries or illnesses during 2015?

   ○ Yes. Go to Section 2: Summary of Work-Related Injuries and Illnesses, 2015, directly below.

   ○ No.   Go to Section 4: Submit Your Data to the Bureau of Labor Statistics (BLS).

Section 2: Summary of Work-Related Injuries and Illnesses, 2015

Instructions:

1. Refer to the OSHA Forms for Recording Work-Related Injuries and Illnesses for the location referenced on the survey instruction sheet under "Report for."
2. If more than one establishment is noted on the survey instruction sheet you received in the mail, please provide information for all of the establishments specified.
3. If any total is zero on your OSHA Form 300A, enter "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 2015, please tell us in the Comments in Section 4 of this survey where you assigned/classified each death within the list of items (M1) through (M6) provided under Injury/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 2015:

Step 1: Calculate the Total Number of Employees
Determine the number of paid employees in each pay period. Count full-time, part-time, temporary, seasonal, salaried, and hourly workers. Sum the number of employees for all pay periods (See example 1).

Example 1:
Acme Construction paid its employees in 12 pay periods during 2015:

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: Calculate the Average Annual Employees
Divide the total number of employees from Step 1 by the number of pay periods. Round the result to the next highest number.
(See examples 2 and 3)

Example 2:
Acme Construction had 12 pay periods and paid a total of 392 employees during these pay periods.

392 divided by 12 = 32.67

Example 3:
Acme would round 32.67 to 33.

Steps to estimate total hours worked by all employees for 2015:

Step 1: Determine the number of full-time employees.
(See example 1)

Example 1:
Of Acme's 33 employees in 2015, 28 were full-time.

Step 2: Determine the number of hours generally worked by full-time employees for a year. Exclude:
- Vacation
- Sick leave
- Holiday and any non-work time

Step 3: Multiply the number of full-time employees by the number of hours generally worked.
(See example 2)

Example 2:
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 4: Determine the number of overtime worked by full-time employees.

Step 5: Determine the number of hours worked by non full-time employees. Include:
- Part-time workers
- Seasonal workers
- Temporary workers

Example 3:
Acme's 28 full-time employees worked a total of 2,800 hours of overtime during 2015 and 56,000 regular hours. Acme's 5 part-time employees worked a total of 2,715 hours during 2015.

Step 6: Estimate Total Hours worked
- Add the number of full-time worker hours, overtime hours, and the part-time worker hours to calculate the estimated number of hours worked for all employees.
(See example 3)

```
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:

Please refer to your records of days away from work cases to complete this section. If you maintain these records on the OSHA Form 300, *Log of Work-Related Injuries and Illnesses*, these cases will be indicated by checks in Column H (see sample below).

If you had cases with days away from work in Column H, please complete Section 3 (starting on the next page). You should only report cases with days away from work.

If you had **NO** cases with days away from work in Column H, you are finished with the survey. Proceed to Section 4 to submit your data to BLS.

We have designed this survey so that you should not have to report more than approximately 15 cases. **If you have more than 15 cases**, please contact the state agency at the phone number listed on the front of the survey instructions you received in the mail.

Step 1: Fill out one "Case with Days Away from Work" form for each work-related injury or illness resulting in days away from work. The requested information can be found on documents such as:
·The *Injury and Illness Incident Report* (OSHA Form 301);
·A worker's compensation report;
·An accident report; or
·An insurance form.

Step 2: If more than one establishment is noted on the survey instructions under "Report For," be sure to look at all your OSHA Form 300's to find which cases to report.

Step 3: If you had an injury or illness that resulted in death, please include a comment in the comment field in Section 4.

Step 4: When you are finished, proceed to Section 4 to submit your data to BLS.

Case with Days Away from Work

Tell us about a 2015 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)
[ ]	[ ]	MM ▾ DD ▾ 2015	[ ]	[ ]

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   ○ Healthcare

   ○ Sales   ○ Delivery or driving

   ○ Product assembly, product manufacture   ○ Food service

   ○ Repair, installation or service of machines, equipment   ○ Cleaning, maintenance of building, grounds

   ○ Construction   ○ Material handling (e.g. stocking, loading/ unloading, moving etc.)

   ○ Other [ ]   ○ Farming

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

   ☐ American Indian or Alaska Native   ☐ Native Hawaiian or Other Pacific Islander

   ☐ Asian   ☐ White

   ☐ Black or African American   ☐ Not available

   ☐ Hispanic or Latino

3. Employee's age: [ ]

   OR date of birth: MM ▾ DD ▾ YYYY ▾

4. Employee's date hired: MM ▾ DD ▾ YYYY ▾

   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

6. Was employee treated in an emergency room?

   ○ Yes   ○ No

7. Was employee hospitalized overnight as an in-patient?

   ○ Yes   ○ No

Tell us about the Incident

8. Time employee began work: hh ▾ : 00 ▾

9. Time of event: hh ▾ : 00 ▾ ☐ 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.

    [ ]

[Add New Case] [Remove Case]

Section 4: Submit Your Data to BLS

1. Comment
Provide any additional information you have on the data you are submitting in the space provided. If you had an injury or illness that resulted in death, please tell us what injury/illness type you classified it as in Section 2. (250 character limit)

2. Save
Save a copy of this form for your records.

Save

3. Print
Print a copy of this form for your records.

Print

4. Submit
Click the Submit button to send your data to BLS.

You will receive a confirmation via e-mail within 24 hours of your data being received. If you have JavaScript enabled in your browser, you may also receive a confirmation message within the next 5 minutes when we receive your data.

Submit

5. Keep the confirmation
You will receive an e-mail confirmation from idc.helpdesk@bls.gov within 24 hours.

Keep a copy of the confirmation for your records.

If you do not receive an e-mail confirmation, contact your State at the phone number listed on the front of your survey instructions for assistance in submitting your data.

Thank you for your response and for helping to keep America's workplaces safe.