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Form No. OSHA 6-40.1.

Serious Event Reporting Online Form

Validation Check - Enter State of Event to determine reporting requirements.

* State

Validation Check

Clear Form

NOTE: For employers covered by Federal OSHA that are located in State Plan States, to make a report

- Call the nearest [OSHA office](#).
- Call the OSHA 24-hour hotline at 1-800-321-6742 (OSHA).

OMB Control Number: 1218-0176

Expiration Date: January 31, 2018

Public reporting for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid Office of Management and Budget Control Number. If you have any comments regarding this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to OSHAPRA@dol.gov or to OSHA's Office of Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210.

Serious Event Reporting Online Form

Items noted with an asterisk (*) are required in order to accept your submission.

Information about the location where the incident occurred

***Name of Location (or Description)**

Street Address 1

Street Address 2

***City**

***State**

***County**

***Zip**

GPS Coordinates

Information about the incident

***Date incident occurred** ex. mm/dd/yyyy

***Time incident occurred** ex. 2245

GPS Coordinates

Information about the incident

*Date incident occurred ex. mm/dd/yyyy

*Time incident occurred ex. 2245

*What Happened?

Additional Information

Number of Fatalities

Number of Hospitalizations

Employer Information

*Legal Business Name

Other Name

*Street Address 1

Street Address 2

*City

*State

Information for persons who OSHA can contact

Contact #1

*First name
*Last name
*Title
*Work Phone
Cell Phone
*Email Address

Contact #2

First name
Last name
Title
Work Phone
Cell Phone
Email Address

Information for Each of the Victims

Information for Each of the Victims

*Victim First name

*Victim Last name

What was the employee doing just before the incident occurred?

*What was the injury or illness?

What object or substance directly harmed the employee?

Was there a fatality?

- Yes
- No

Was victim hospitalized?

- Yes
- No

Was there an amputation?

- Yes
- No

Was there the loss of an eye?

- Yes
- No

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