

Survey of Occupational Injuries and Illnesses, 2018



YOUR RESPONSE IS REQUIRED BY LAW WITHIN 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. Per the Federal Cybersecurity Enhancement Act of 2015, Federal information systems are protected from malicious activities through cybersecurity screening of transmitted data.

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 2018 on your Occupational Safety and Health Administration (OSHA) *Forms for Recording Work-Related Injuries and Illnesses*. Copies of these forms were sent to you in late 2017. 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 2018. The instructions below outline the steps to complete the survey regardless of whether your establishment did or did not have injuries or illnesses in 2018.

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 in the **“For Help Call:”** section.

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 sent to you in late 2017. Form 300A from that mailing is shown immediately below.

OSHA's Form 300A (Rev. 01/2004)
Summary of Work-Related Injuries and Illnesses
 Year 20____
 U.S. Department of Labor
 Occupational Safety and Health Administration

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
(D)	(P)	(R)	(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

Establishment information

Your establishment name _____
 Street _____
 City _____ State _____ Zip _____
 Industry description (e.g., Manufacturer of motor truck trailers) _____
 Standard Industrial Classification (SIC), if known (e.g., SIC 2715) _____
 OR
 North American Industrial Classification (NAICS), if known (e.g., 336212) _____

Employment information (If you don't have these figures, see the Worksheet on the back of this page to estimate.)

Annual average number of employees _____
 Total hours worked by all employees last year _____

Sign here

Knowingly falsifying this document may result in a fine.
 I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.

 Title _____

Copy this information to Section 2 of this survey.

Copy this information to Section 1 of this survey.

Copy your “User ID” from the label to Section 1.

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

Example

User ID:

302123456789

Temporary Password:

9876Nsu

NAICS code location.

77-123456789-1
 2013-1 NAICS 238000 12 P 60 00

NAICS code location.

- If you had **no** work-related injuries or illnesses in 2018, answer all questions in Sections 1 and 4 of the survey.
- If you had at least one work-related injury or illness in 2018, answer all questions in Sections 1, 2 and 4 of the survey.
- Report cases with **Days Away From Work** (with or without days of job transfer or restriction) in Section 3.
- Report cases with **Job Transfer or Restriction** (without days away from work) in Section 3 if you are reporting for a private industry establishment whose six-digit NAICS code begins with these numbers: **111, 336, 445, 484, 713, or 722** (see mailing label example for NAICS code location).

Step 4: In case we have questions, write the name of the person who completed this survey in Section 4: Contact Information, on the last page 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.

Section 1: Establishment Information

Instructions: Using your completed Calendar Year 2018 *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 "User ID" from the front cover. →
2. Enter the annual average number of employees for 2018. →
3. Enter the total hours worked by all employees for 2018. →
4. Check any conditions that might have affected your answers to questions 2 and 3 above during 2018:

<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="checkbox"/> Natural disaster or adverse weather conditions	<input type="checkbox"/> Nothing unusual happened to affect our employment or hours figures
5. Did you have ANY work-related injuries or illnesses during 2018?
 - Yes. Go to Section 2: Summary of Work-Related Injuries and Illnesses, 2018, directly below.
 - No. Go to Section 4: Contact Information, on the back cover.

Section 2: Summary of Work-Related Injuries and Illnesses, 2018

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 2018, 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 2018:

Step 1:

To calculate the annual average number of employees your establishment paid during 2018, 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 2018. 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 2018:

<u>Pay Period</u>	<u>Number of Employees Paid</u> <u>Per Pay Period</u>
1	30
2	0
3	35
4	37
5	37
6	40
7	43
8	42
9	37
10	35
11	30
12	<u>+26</u>
	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 2018. 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 2018:

Step 1:

Determine the number of full-time employees at your establishment.

Example:

Of Acme's 33 employees in 2018, 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
<u>X 2,000</u>	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 2018. 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 2018 and 56,000 regular hours. Acme's 5 part-time employees worked a total of 2,716 hours during 2018.

56,000	full-time hours from Step 2
2,800	over time hours
<u>+ 2,716</u>	part-time hours
61,516	total hours worked

Section 3: Reporting Cases

Instructions:

1. If you had **NO** cases with days away from work (Column H) and **NO** cases with days of job transfer or restriction (Column I), please proceed to Section 4: Contact Information.
2. If you had cases with days away from work (Column H) and/or cases with days of job transfer or restriction only (Column I), please complete Section 3. You should report all cases with days away from work (with or without job transfer or restriction). If you are reporting for a private industry establishment whose six-digit **NAICS code begins with: 111, 336, 445, 484, 713, or 722**, you should also report all cases with days of job transfer or restriction (without days away from work). Your NAICS code is located on the mailing label on the front of this booklet. 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) and/or Column (I). These are the only cases you should report. See the illustration in Step 3 below.

Step 2: Fill out one Injury and Illness Case 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

Year 20

U.S. Department of Labor
 Occupational Safety and Health Administration
Form approved OMB no. 1218-0176

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.B through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Establishment name _____
 City _____ State _____

Identify the person		Describe the case			Classify the case <small>CHECK ONLY ONE box for each case based on the most serious outcome for that case:</small>				Enter the number of days the injured or ill worker was		Check the "Injury" column or choose one type of illness:									
(A) Case no.	(B) Employee's name	(C) Job title <small>(e.g., Welder)</small>	(D) Date of injury or onset of illness	(E) Where the event occurred <small>(e.g., Loading dock north end)</small>	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill <small>(e.g., Second degree burns on right forearm from acetylene torch)</small>	Remained at Work				Away from work (K) / On job transfer or restriction (L)		(M)								
						Death (G)	Days away from work (H)	Job transfer or restriction (I)	Other recordable cases (J)			Days away from work (K)	On job transfer or restriction (L)	Injury (1)	Skin disorder (2)	Respiratory condition (3)	Repetitive trauma (4)	Illness (5)	All other illnesses (6)	
														<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
														<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
														<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
														<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
														<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
														<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
														<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
														<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
														<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
														<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
														<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
														<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
														<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 3 asks about injuries or illnesses with a check in Column H, Days Away from Work and/or Column I, Job Transfer or Restriction, of your Log.

Page totals ➔

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistical Analysis, Room N-9056, 209 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Be sure to transfer these totals to the Summary page (Form 300A) before you post it.

Page ___ of ___

Step 4: We have designed this survey to ensure that you do not have to report more than approximately 16 cases. If you have significantly more than 16 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 additional Injury and Illness Case 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.

Injury and Illness Case Form

Tell us about a 2018 work-related injury or illness **only** if it resulted in days away from work or job transfer/restriction. To find out which case(s) you should report, read the instructions at the beginning of **Section 3: Reporting Cases**.

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)
		____ / ____ / 18 <small>month day year</small>	_____	_____

Tell us about the Employee

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

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

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.

N	P	S	E	SS	OCC
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Injury and Illness Case Form

Tell us about a 2018 work-related injury or illness **only** if it resulted in days away from work or job transfer/restriction. To find out which case(s) you should report, read the instructions at the beginning of **Section 3: Reporting Cases**.

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)
		____ / ____ / 18 <small>month day year</small>		

Tell us about the Employee

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

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

8. Was employee treated in an emergency room? yes no
9. 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."

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.

N	P	S	E	SS	OCC
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Section 4: Contact Information

Fill in the name, title, and phone number of the person who completed this survey in case we have questions.

_____	() - _____	_____	() - _____
<i>Printed name</i>	<i>Telephone number</i>	<i>Ext.</i>	<i>Fax number</i>
_____	/ / _____		
<i>Title</i>	<i>Today's date</i>		

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) 956-7440, 7444 (334) 956-7467, 7442 (334) 956-7492 fax	Illinois (217) 524-2098 (217) 558-4122 fax	Nebraska (402) 471-3547, 1545 (800) 599-5155 (402) 471-6523 fax	Rhode Island (617) 565-2302 (617) 565-3847 fax
Alaska (907) 465-6034 (907) 465-4506 fax	Indiana (317) 232-2668 (317) 233-3790 fax	Nevada (866) 931-1215 (702) 486-9197, 9187 (702) 486-9175 fax	South Carolina (803) 896-7659, 7683 (803) 896-7670 fax
Arizona (602) 542-3739 (602) 542-6360 fax	Iowa (515) 725-5611 (515) 725-7924 fax	New Hampshire (617) 565-2302 (617) 565-3847 fax	South Dakota (312) 353-7253 (312) 353-7230 fax
Arkansas (501) 682-4509 (501) 682-4754 fax	Kansas (785) 581-7479 (785) 296-2151 fax	New Jersey (609) 292-8999 (609) 633-0618 fax	Tennessee (615) 741-1748 (800) 778-3966 (615) 253-5501 fax
California (415) 703-3020 (415) 703-3029 fax	Kentucky (502) 564- 4105, 4259 (502) 564- 4137, 4125 (502) 564-0539 fax	New Mexico (505) 476-8740 (505) 476-8735 fax	Texas (866) 237-6405 (512) 804-4652 fax
Colorado (972) 850-4812 (816) 285-7031 (972) 850-4810 fax	Louisiana (225) 342-3126 (225) 342-3269 fax	New York (888) 425-1323 (888) 807-0410 fax	Utah (801) 530-6926, 6823 (801) 536-7906 fax
Connecticut (860) 263-6272 (860) 263-6263 fax	Maine (207) 623-7903 (207) 623-7937 fax	North Carolina (919) 707-7765 (919) 733-2186 fax	Vermont (802) 828-4153 (802) 828-4050 fax
Delaware (302) 761-8221 (302) 762-3590 fax	Maryland (410) 527-4460, 4461, 4462 (410) 527-4497 fax	North Dakota (312) 353-7253 (312) 353-7230 fax	Virgin Islands (340) 776-3700 ext. 2019 (340) 715-5740 fax
District of Columbia (202) 442-9010, 5930, 5926 (202) 442-4833 fax	Massachusetts (617) 626-6945 (617) 626-6944 fax	Ohio (866) 569-7806 (614) 995-8608 (614) 728-6460 fax	Virginia (804) 786-1995 (804) 786-2376 fax
Florida (215) 861-5628, 5637 (215) 861-5736 fax	Michigan (517) 284-7788 (517) 284-7815 fax	Oklahoma (312) 353-7253 (312) 353-7230 fax	Washington (360) 902-5640 (360) 902-4249 fax
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