

Contents


IDCF Log in and registration screens.....	2
Welcome page:.....	4
Dear employer page:.....	5
Contact preference page:.....	5
Add establishment page:.....	6
Help request form:.....	6
Section 1:.....	7
Section 2:.....	8
Section 3 and case entry:.....	9
Case entry screen:.....	10
Alternative Section 3 and case entry wording:.....	14
Additional Section 3 wording alternative:.....	15
Section 4:.....	16
Page asking for OSHA ID:.....	18
Thank you page:.....	21

IDCF Log in and registration screens

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.

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: ⓘ

Your Job Title:

* Your Company Name: ⓘ

* Address: ⓘ

* City: ⓘ

* State: ⓘ

* Zip Code: ⓘ

* Telephone: ⓘ

Fax:

If you have questions or comments please complete and submit the [Help Request Form](#) ⓘ | Version: 10.1.1



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The temporary password is no longer valid, please create a new password.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

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.

302012012201

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.

[Continue](#)

If you have questions or comments please complete and submit the [Help Request Form](#) | Version: 10.1.1

Welcome page:



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
tester22@testing.com
345-345-3455

Test Company
12 Test Way
Nashville TN 34534

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

Dear employer page:



Dear Employer,

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

Forms you will need:

1. The SOII instructions that were sent to you.
2. OSHA forms ([Form 300, 300A, and 301](#)) in *Forms for Recording Work-Related Injuries and Illnesses*.
 - 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 under the *'Report for'* heading in the notification(s) we sent you earlier this year.
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 in the survey instructions under *'For Help Call:'*. For website technical help only, click the helpdesk link at the bottom of the page.

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

[Continue](#) →

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 (44 U.S.C. 3572) and other applicable Federal laws, your responses will not be disclosed in identifiable form without your informed consent. Per the Cybersecurity Enhancement Act of 2015, Federal information systems are protected from malicious activities through cybersecurity screening of transmitted data.

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: 12.3

Contact preference page:



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.

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: 12.2.2

Add establishment page:



BUREAU OF LABOR STATISTICS
Survey of Occupational Injuries and Illnesses

Help | Logout

Make sure the Establishment ID(s) on the mailing form or email attachment match the Establishment ID(s) shown below.

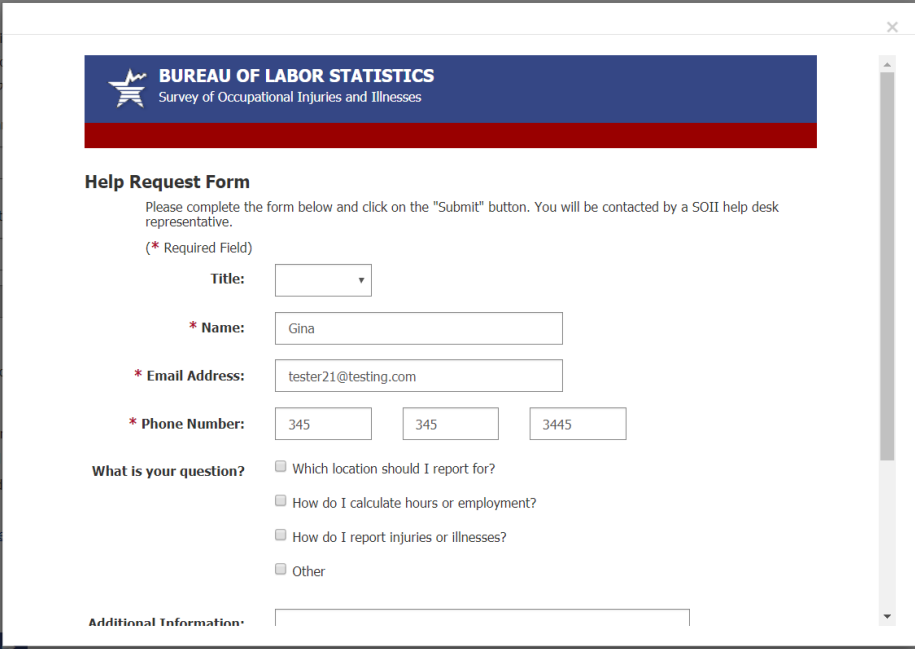
Establishment ID not shown in table? [Add Establishment](#)

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

	Year	Establishment ID	Company Name	Unit Description	Notification Preference	Status	
Select	2018	01-010010010-0	Testing Company	1ST AVE	tester21@testing.com	Complete	Remove

Help request form:

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. The Help Request Form is shown below. This year we added a Salutation drop down so that our helpdesk staff can address users properly:



BUREAU OF LABOR STATISTICS
Survey of Occupational Injuries and Illnesses

Help Request Form

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

(* Required Field)

Title:

*** Name:**

*** Email Address:**

*** Phone Number:**

What is your question?

- Which location should I report for?
- How do I calculate hours or employment?
- How do I report injuries or illnesses?
- Other

Additional Information:


Save & Continue

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

Version: 12.2.2

After submitting the help request, the user will return to the section they are on and press "Save and Continue" to proceed through the survey.

Section 1:

**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: 01-010010010-0
[Add comments](#)

[Update](#)

Test Company
Address Below.

123 TEST street
Charleston, IL 61920

Notification Preference : shepherd.kenneth_test@bls.gov

- Complete this survey only for the location(s) listed under 'Report for' in your survey notification.
- Copy the information from your completed Calendar Year 2019 *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.

- Enter the annual average number of employees for 2019.
 [Help me calculate this](#)
- Enter the total hours worked by all employees for 2019.
 [Help me calculate this](#)
 Annual average hours worked per employee
- Check any conditions that might have affected your annual average number of employees or total hours worked during 2019:

<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"/> Nothing unusual happened to affect our employment or hours figures
<input type="checkbox"/> Natural disaster or adverse weather conditions	<input type="checkbox"/> Other reason: <input style="width: 100px;" type="text"/>
- [Did you have ANY work-related injuries or illnesses during 2019?](#)
 Yes
 No

[Save & Continue →](#)

Section 2:



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, 2019

Establishment ID: 01-010010010-0
[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

(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 report a death the bottom of section 2 looks like this:

Injury and Illness Types	
Total number of... (M)	
1. Injuries	<input type="text" value="1"/>
2. Skin disorders	<input type="text" value="1"/>
3. Respiratory conditions	<input type="text" value="1"/>
4. Poisonings	<input type="text" value="1"/>
5. Hearing loss	<input type="text" value="1"/>
6. All other illnesses	<input type="text" value="1"/>

If you have had any work-related deaths in 2019, please tell us where you assigned/classified each death within the list of items (M1) through (M6) provided under **Injury and Illness Types** above.

Injury and Illness Type	Number of Deaths
All Other Illnesses	<input type="text" value="1"/>
Hearing Loss	<input type="text"/>
Poisonings	<input type="text"/>
Respiratory Conditions	<input type="text"/>
Skin Disorders	<input type="text"/>
Injuries	<input type="text"/>

Save & Continue →

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

Version: 12.3

Section 3 and case entry:

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 3. Cases with Days Away from Work

In Section 2 you reported: Establishment ID: 01-010010010-0

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
<input type="button" value="Enter Case 1"/>				
<input type="button" value="Enter Additional Case"/>				

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

Version: 12.2.2

Case entry screen:

(1 of 3):

Enter Information about a Case with Days Away from Work

To complete the information below, you will need:

Establishment ID: 01-010010010-0

- Your completed copy of your OSHA Form 300 for 2019.
- 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 2019 work-related injury or illness ONLY if it resulted in days away from work.

Employee's name (column B)	<input type="text" value="John"/>
Job title (column C)	<input type="text" value="Doe"/>
<u>Date of injury or onset of illness</u> (column D)	<input type="text" value="05-May"/> <input type="text" value="11"/> <input type="text" value="2019"/>
<u>Number of days away from work</u> (column K)	<input type="text" value="1"/>
<u>Number of days of job transfer or restriction</u> (column L)	<input type="text" value="0"/>

1. Select 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"/> Repair, installation or service of machines, equipment |
| <input type="checkbox"/> Healthcare | <input type="checkbox"/> Cleaning, maintenance of building, grounds |
| <input type="checkbox"/> Sales | <input checked="" type="checkbox"/> Construction |
| <input type="checkbox"/> Delivery or driving | <input type="checkbox"/> Material handling (e.g. stocking, loading/unloading, moving, etc.) |
| <input type="checkbox"/> Product assembly, product manufacture | <input type="checkbox"/> Farming |
| <input type="checkbox"/> Food Service | <input type="checkbox"/> Other: <input type="text"/> |

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:

Case entry screen (2 of 3):

4. Employee's date hired: 05-May 5 2016

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

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

- Yes
- No

8. Time employee began work: 10 am 34

9. Time of event: 11 am 21

OR

Check if time cannot be determined

Event occurred:

- Before
- During
- After work shift

Case entry screen (3 of 3):

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)

Mopping

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)

Slipped on water and fell

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)

Bruised 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)

Floor

14. Case Comments:

Enter additional case information here (optional).

Save & Continue →



- 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

In Section 2 you reported:

Establishment ID: 01-010010010-0

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	Doe	05/11/2019	1	0	Delete

[Enter Additional Case](#)


[Continue →](#)

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

Version: 12.3

Alternative Section 3 and case entry wording:

Alternative section 3 and case screen for if establishment has to report case details for days of job transfer or restriction cases in addition to their days away from work cases:

**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 3. Cases with Days Away from Work, Job Transfer, or Restriction

In Section 2 you reported: Establishment ID: **01-010010010-0**

- 1 case(s) with days away from work (Column H)
- 2 case(s) with job transfer or restriction (Column I)

Enter data for cases with days away from work, job transfer, or restriction in the table below.

Employee's Name	Job Title	Date of Injury	Days	
			Away from Work	of Restriction
<input type="text" value="Enter Case 1"/>				
<input type="text" value="Enter Case 2"/>				
<input type="text" value="Enter Case 3"/>				

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

Version: 12.3

Case screen:

Enter Information about a Case with Days Away from Work, Job Transfer, or Restriction

To complete the information below, you will need:

Establishment ID: **01-010010010-0**

- Your completed copy of your OSHA Form 300 for 2019.
- 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 2019 work-related injury or illness **ONLY** if it resulted in days away from work or job transfer or restriction.

Employee's name (column B)

Job title (column C)

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

Rest of case screen is the same as other section.

Additional Section 3 wording alternative:

Alternative section 3 screen where user is only asked to report case details for cases that occurred during the indicate date ranges:



Section 3. Cases with Days Away from Work, Job Transfer, or Restriction

In Section 2 you reported:

Establishment ID: **01-010010010-0**

- 15 case(s) with days away from work (Column H)
- 5 case(s) with job transfer or restriction (Column I)

Enter data for cases with days away from work, job transfer, or restriction. Only report cases that occurred **during February, April, June, August, October, and December.**

Section 4:

(1 of 2)



Review your data

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

Section 1. Establishment Information

Establishment ID: 01-010010010-0

Establishment Address

Test Company
123 TEST street
Charleston, IL 61920

Employment Information

- Annual average number of employees: 500
- Total hours worked by all employees last year: 200000

Conditions that might have affected your annual average number of employees or total hours worked during 2019:

- | | |
|---|---|
| <input type="checkbox"/> Strike or lockout | <input checked="" 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"/> Nothing unusual happened to affect our employment or hours figures |
| <input type="checkbox"/> Natural disaster or adverse weather conditions | <input type="checkbox"/> Other reason: |

Section 2. Summary of Work-Related Injuries and Illnesses, 2019

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	2	3
(G)	(H)	(I)	(J)
Number of Days			
Total number of days away from work	Total number of days of job transfer or restriction		
4	5		
(K)	(L)		
Injury and Illness Types			
Total number of... (M)	(1) Injuries	(4) Poisonings	0
	(2) Skin disorders	(5) Hearing loss	0
	(3) Respiratory conditions	(6) All other illnesses	1

Establishment Comments - Section 1 & Section 2

- No comments to report.

Section 4 (2 of 2):

Section 3. Cases with Days Away from Work

Case 1

Employee Name: **John**

Job Title: **Doe**

Date of Injury or onset of illness: **05/11/2019**

Number of days away from work: **1**

Number of days of job transfer or restriction: **0**

1. Type of Job or Work: **Construction**
2. Employee's race or ethnic background:
 - **White**
3. Employee's age:
 - Date of birth: **04/15/1987**
4. Employee's date hired: **05/05/2016**
 - Employee's length of service when incident occurred:
5. Employee's gender: **Male**
6. Treated in emergency room? **Yes**
7. Hospitalized overnight as in-patient **Yes**
8. Time employee began work: **10:34 AM**
9. Time of event: **11:21 AM**
10. What was the employee doing before the incident?
Mopping
11. What happened?
Slipped on water and fell
12. What was the injury or illness?
Bruised elbow
13. What object or substance directly harmed the employee?
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: 12.3

Sample OSHA ITA submission reply: Clicking on the ? icon at the end of question 2 provides a sample email that OSHA ITA respondents received upon successful submission to ITA. (Note: this example opens on a separate browser tab.)

OSHA sends an email after receiving data in the Injury Tracking Application. The email contains the 6 digit ID, and looks like this:

From: DoNotReply@osha.gov on behalf of Occupational Safety and Health Administration <DoNotReply@osha.gov>
Sent: Thursday, February 01, 2018 11:26 AM
To: **Email Address**
Subject: OSHA Injury and Illness Report: Successful Submission(s)

On February 1, 2018 at 11:26 am you **successfully submitted** data for the following 1 establishment(s) in the injury tracking application.

ID	Name	Address
123456	Establishment Name	Establishment Address City, State, Zip

If you have any questions, you can contact OSHA using the Support Webform.

Thank you,
ITA Team

Thank you page:

Seen either after the OSHA ID page or directly after section 4.

Thank you for Reporting!

Establishment ID: 01-010010010-0

Your data were received by BLS on 11/01/2019 at 01:27 PM EDT.

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 questions arise during review of the data, a Bureau of Labor Statistics representative may contact you for clarification.

If you are included in the 2020 survey, the survey materials will be sent to you in January 2021.

[Enter data for another establishment](#)

[Return to SOIT Home Page](#)

[Return to IDCF Home Page](#)

[Print Submission](#)

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

Version: 12.3