Bureau of Labor Statistics
Census of Fatal
Occupational Injuries Report

U.S. Department of Labor

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

Return to:

For assistance call:

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

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

SECTION I. DECEASED WORKER AND EMPLOYER

NAME: _____

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

2. **Social Security Number:** _____

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

   _____
   (Company name)

   _____
   (Street address)

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

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

4. **Date of birth:** _____
(Month) (Day) (Year)

5. **Ethnicity and race:** *(Select one or more: if unknown leave blank)*

- ❑ American Indian or Alaska Native
- ❑ Black or African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Asian
- ❑ Hispanic or Latino
- ❑ White

6. **Gender:** ❑ Male ❑ Female

7. **In what state did the deceased reside?** _____

SECTION II. EMPLOYMENT INFORMATION

1. **Which of the following BEST describes the deceased's employment status at the time of the incident?** *(Check only **ONE**)*

- ❑ Active duty, Armed Forces
- ❑ Self-employed, partner, or owner of a business, farm, or professional practice
  (*Check only **ONE**:* ❑ incorporated ❑ unincorporated)
- ❑ Working for the family business, except owner (includes paid or unpaid work)
- ❑ Working for pay or other compensation (such as room and board) in other than the family business
- ❑ Working as a volunteer without pay or other compensation
- ❑ Other (*Please specify:*) _____
- ❑ Don't know

2. **Occupation of deceased at the time of the incident:** *(Examples include: cashier, drywall installer, farm foreman)* _____

3. **How long did the deceased work in the position held at the time of the incident?**

[ ] years [ ] months *(if less than 1 year)*

4. **Which of the following <u>best</u> describes the type of employer the deceased was directly employed by?** *(Check only **ONE**)*

- ❑ a private company or self-employed
- ❑ a local government agency
- ❑ a State government agency
- ❑ a Federal government agency
- ❑ a foreign or international government agency
- ❑ other governmental body, such as a regional or interstate commission

5. **Describe the nature of the business or the main type of activity performed by the direct employer at the establishment.** (*Examples include: manufacturer of storage batteries, grocery store, computer programming services, etc.)*

_____

6. **On average, about how many persons work for the establishment of the direct employer?** *(Check only **ONE**)*

❑ 1-10 ❑ 11-19 ❑ 20-49 ❑ 50-99 ❑ 100 or more ❑ don't know

SECTION III. INFORMATION ABOUT THE INCIDENT

1. **Date of death:** _____
(Month) *(Day)* *(Year)*

2. **State in which death occurred:** _____

3. **Date the incident occurred:** _____
(Month) *(Day)* *(Year)*

4. **Where did this incident occur?**

State: _____

County: _____

Type of location (*Examples include: farm, highway, bank, etc.):*
_____

5. **Did the incident occur on the direct employer's premises?**

❑ No
❑ Yes ⟶ ***If YES*, where did the incident occur?**

❑ in a work area
❑ in the company parking lot
❑ on an outside walkway
❑ in a recreational area
❑ in a hallway, stairway, rest room, or cafeteria
❑ some other place (*Please specify):*
_____
❑ don't know

6. **Was the site where the employee was working at the time of the incident under the control of his/her direct employer, or was the employee working at a site where a different company exercised overall responsibility for the operations at the site?**

❑ Direct employer
❑ Different company ⟶ ***If different company:***

a. **Describe the nature of the business or the main type of activity performed by this different company at the establishment.** (For example, a plumber for a repair firm was killed while working at a restaurant to fix a dishwasher. The direct employer is the repair firm since it paid the plumber's wages. The different company is the restaurant since it exercised overall responsibility for the operations at the site)

_____

b. **Which of the following <u>best</u> describes the type of employer this different company is?** *(Check only **ONE**)*

❑ a private company
❑ a local government agency
❑ a State government agency
❑ a Federal government agency
❑ a foreign or international government agency
❑ other governmental body, such as a regional or interstate commission

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

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

8. What time did the incident occur? [ ] *Check only **ONE**:* ❑ AM ❑ PM

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

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

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

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

a. Include information about how the injury/illness occurred.

b. Identify any equipment, objects, or substances involved in the incident and describe how they were involved. *(Please use additional pages if more space is needed.)*

_____

_____

_____

_____

SECTION IV. RESPONDENT IDENTIFICATION

Please provide the following information:

1. Your name: _____

2. Your job title: _____

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

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