

# Survey of Occupational Injuries and Illnesses, 2024



**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 30 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 email them to the Bureau of Labor Statistics, Occupational Safety and Health Statistics (1220-0045) at [OSHS\\_Public@bls.gov](mailto:OSHS_Public@bls.gov). Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. **DO NOT EMAIL 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 (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 Federal Cybersecurity Enhancement Act of 2015, Federal information systems are protected from malicious activities through cybersecurity screening of transmitted data.

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 2024 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 2024. 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 2024. The instructions below outline the steps to complete the survey regardless of whether or not your establishment had injuries or illnesses in 2024.

- 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 2024. Form 300A from that mailing is shown immediately below.

OSHA's Form 300A (Rev. 01/2024) Year 20\_\_  
**Summary of Work-Related Injuries and Illnesses**  
 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
(P)	(R)

**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 engines): \_\_\_\_\_  
 Standard Industrial Classification (SIC), if known (e.g., SIC 3715): \_\_\_\_\_  
 OR  
 North American Industrial Classification (NAICS, if known (e.g., 336212): \_\_\_\_\_

**Employment information** (If you don't have these figures, use the Worksheet on the last 3 of this page to estimate.)

Annual average number of employees: \_\_\_\_\_  
 Total hours worked by all employees last year: \_\_\_\_\_

**Sign here**

Knowing 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.

Employer (Print Name) \_\_\_\_\_ Date \_\_\_\_\_  
 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.

NAICS code location.

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

**User ID:**  
 302123456789

**Your Company Address:**  
 YOUR COMPANY NAME  
 987 YOUR STREET  
 YOUR CITY, US 98765-0000

**Temporary Password:**  
 9876Nsu

77-123456789-1  
 2020-1 NAICS 238000 12 P 60 00

- If you had **no** work-related injuries or illnesses in 2024, answer all questions in Sections 1 and 4 of the survey.
  - If you had at least one work-related injury or illness in 2024, answer all questions in Sections 1, 2 and 4 of the survey.
  - Report cases with **Days Away From Work, or with Job Transfer or Restriction** in Section 3.
- 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 2024 *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 2024. →
3. Enter the total hours worked by all employees for 2024. →
4. Check any conditions that might have affected your answers to questions 2 and 3 above during 2024:
 

<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 2024?
  - Yes. Go to Section 2: Summary of Work-Related Injuries and Illnesses, 2024, directly below.
  - No. Go to Section 4: Contact Information, on the back cover.

# Section 2: Summary of Work-Related Injuries and Illnesses, 2024

**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).

<b>Number of Cases</b>			
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)
<b>Number of Days</b>			
Total number of days away from work	Total number of days of job transfer or restriction		
(K)	(L)		
<b>Injury and Illness Types</b>			
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 2024, 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 2024:

### Step 1:

To calculate the annual average number of employees your establishment paid during 2024, 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 2024. 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 2024:

<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 2024. 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 2024:

### Step 1:

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

### Example:

Of Acme's 33 employees in 2024, 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 2024. 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 2024 and 56,000 regular hours. Acme's 5 part-time employees worked a total of 2,716 hours during 2024.

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) or cases with days of job transfer or restriction (Column I), please complete Section 3. 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) 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**

**Attention:** This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

**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 1904.8 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 CHECK ONLY ONE box for each case based on the most serious outcome for that case.				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 (e.g., Welder)	(D) Date of injury or onset of illness	(E) Where the event occurred (e.g., Loading dock north end)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g., Second degree burns on right forearm from acetylene torch)	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)			Injury	Skin disorder	Respiratory condition	Poisoning	Hearting/vascular	All other illnesses	
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ days _____ days	_____ days _____ days	<input type="checkbox"/>	(1) <input type="checkbox"/>	(2) <input type="checkbox"/>	(3) <input type="checkbox"/>	(4) <input type="checkbox"/>	(5) <input type="checkbox"/>	(6) <input type="checkbox"/>
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# Injury and Illness Case Form

Tell us about each 2024 work-related injury or illness case if it resulted in days away from work (Column H in Section 2 on Page 3) or days of job transfer or restriction (Column I in Section 2 on Page 3). One *Injury and Illness Case Form* should be completed for each injury or illness case. We have designed this survey to ensure that you do not have to report more than 8 cases. If you have more than 8 cases, please contact the office whose number appears on the front of the survey form.

## 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)
_____	_____	____/____/24 <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.

# Injury and Illness Case Form

Tell us about each 2024 work-related injury or illness case if it resulted in days away from work (Column H in Section 2 on Page 3) or days of job transfer or restriction (Column I in Section 2 on Page 3). One *Injury and Illness Case Form* should be completed for each injury or illness case. We have designed this survey to ensure that you do not have to report more than 8 cases. If you have more than 8 cases, please contact the office whose number appears on the front of the survey form.

## 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)
_____	_____	____/____/24 <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.

## 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.

<b>Alabama</b> (334) 956-7440, 7444 (334) 956-7492 fax	<b>Illinois</b> (217) 524-2098 (217) 558-4122 fax	<b>Nebraska</b> (402) 471-3547, 1545 (800) 599-5155 (402) 471-6523 fax	<b>Rhode Island</b> (617) 565-2302 (617) 565-1840 fax
<b>Alaska</b> (907) 465-6034 (907) 465-4506 fax	<b>Indiana</b> (317) 232-2668 (317) 233-3790 fax	<b>Nevada</b> (866) 931-1215 (702) 486-9197, 9187 (702) 486-9175 fax	<b>South Carolina</b> (803) 896-7659, 7683 (803) 896-7670 fax
<b>Arizona</b> (602) 542-3739 (602) 542-6360 fax	<b>Iowa</b> (515) 725-5611 (515) 725-7924 fax	<b>New Hampshire</b> (617) 565-2302 (617) 565-1840 fax	<b>South Dakota</b> (312) 353-7253 (312) 353-7230 fax
<b>Arkansas</b> (501) 682-4872 (501) 682-4509 (501) 682-4754 fax	<b>Kansas</b> (785) 581-7479 (785) 291-6084 fax	<b>New Jersey</b> (609) 984-3604 (609) 633-0618 fax	<b>Tennessee</b> (615) 741-1748 (800) 778-3966 (615) 253-5501 fax
<b>California</b> (415) 703-3020 (415) 703-3029 fax	<b>Kentucky</b> (502) 564- 4105, 4259 (502) 564-0539 fax	<b>New Mexico</b> (505) 699-6194 (505) 699-7188 (505) 476-8735 fax	<b>Texas</b> (866) 237-6405 (512) 804-4652 fax
<b>Colorado</b> (720) 248-8379 (972) 850-4810 fax	<b>Louisiana</b> (225) 342-3126 (225) 342-3269 fax	<b>New York</b> (888) 425-1323 (888) 807-0410 fax	<b>Utah</b> (801) 530-6926, 6823 (801) 526-9206 fax
<b>Connecticut</b> (860) 263-6272 (860) 263-6263 fax	<b>Maine</b> (207) 623-7903 (207) 623-7937 fax	<b>North Carolina</b> (919) 707-7765 (919) 733-2186 fax	<b>Vermont</b> (802) 828-4327 (802) 760-7101 (802) 828-4050 fax
<b>Delaware</b> (302) 451-3412 (302) 451-3497 fax	<b>Maryland</b> (410) 527-4460, 4462 (410) 527-4497 fax	<b>North Dakota</b> (312) 353-7253 (312) 353-7230 fax	<b>Virgin Islands</b> (340) 776-3700 ext. 2074 (340) 715-5740 fax
<b>District of Columbia</b> (202) 442-9010, 5930, 5926 (202) 442-4833 fax	<b>Massachusetts</b> (617) 626-6945 (978) 577-1556 fax	<b>Ohio</b> (866) 569-7806 (614) 995-8608 (614) 728-6460 fax	<b>Virginia</b> (804) 786-1995 (804) 786-2376 fax
<b>Florida</b> (908) 928-1327 (215) 861-5637 (215) 861-5736 fax	<b>Michigan</b> (517) 284-7788 (517) 284-7815 fax	<b>Oklahoma</b> (405) 521-6599, 6858 (405) 521-6021 fax	<b>Washington</b> (360) 902-5640 (360) 902-5559 fax
<b>Georgia</b> (404) 893-1934, 8344 (404) 893-8343 fax	<b>Minnesota</b> (888) 589-6322 (651) 284-5726 fax	<b>Oregon</b> (503) 947-7030 (503) 947-7312 fax	<b>West Virginia</b> (304) 558-2660 (304) 957-7635 fax
<b>Guam</b> (671) 300-6339 (671) 475-7063 fax	<b>Mississippi</b> (312) 353-7253 (312) 353-7230 fax	<b>Pennsylvania</b> (800) 238-9412 (717) 772-8319 fax	<b>Wisconsin</b> (800) 884-1273 (608) 221-6292 (608) 221-6297 fax
<b>Hawaii</b> (808) 586-9001 (808) 586-9022 fax	<b>Missouri</b> (573) 751-3802, 2719 (573) 751-2319 fax	<b>Puerto Rico</b> (787) 754-5300, ext. 3032, 3036, 3051, 3056, 3057 (787) 754-5360 fax	<b>Wyoming</b> (307) 473-3838 (307) 473-3863 fax
<b>Idaho</b> (415) 625-2275, 2267 (415) 625-2294 fax	<b>Montana</b> (406) 444-3297, 3235 (406) 444-4140 fax		