U.S. Department of Labor
Bureau of Labor Statistics

OMB No. 1220-0045

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. 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

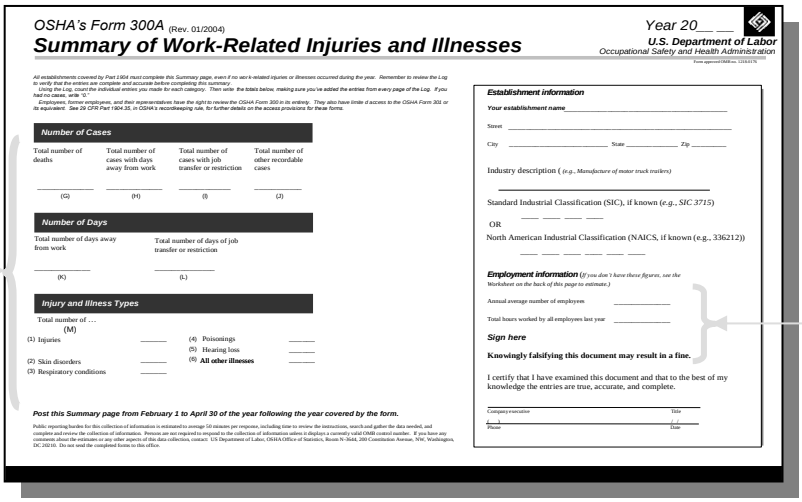
This survey requires employers to provide information about work-related injuries and illnesses based upon the information you have maintained for Calendar Year 2024 on your Occupational Safety and Health Administration (OSHA) *Forms for Recording Work-Related Injuries and Illnesses*. Copies of these 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.

Copy this information to Section 2 of this survey.



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

Form approved OMB no. 1218-0176

All establishments covered by Part 1904 must complete this Summary page, even if no work-related injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate before completing this summary.
Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the Log. If you had no cases, write "0."
Employees, former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limits of access to the OSHA Form 301 or its equivalent. See 29 CFR Part 1904.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms.

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	
		(5) Hearing loss	
(2) Skin disorders		(6) **All other illnesses**	
(3) Respiratory conditions			

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

Public reporting burden for this collection of information is estimated to average 50 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 the estimates or any other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Establishment information

Your establishment name_____

Street _____

City _____ State _____ Zip _____

Industry description (*e.g., Manufacture of motor truck trailers)*

_____

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, 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.

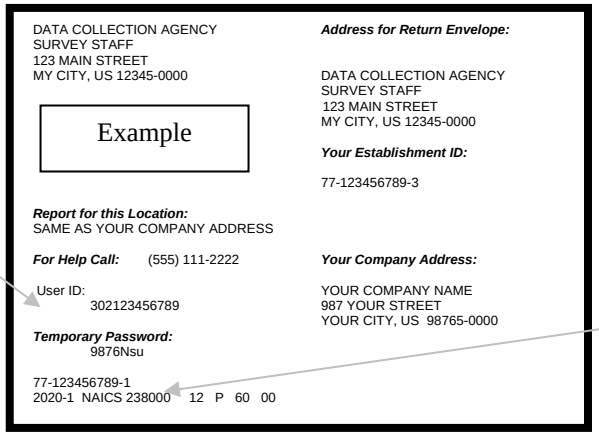
I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.

Company executive _____ Title _____

Phone _____ Date _____

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

Example

Report for this Location:
SAME AS YOUR COMPANY ADDRESS

For Help Call: (555) 111-2222

User ID:
302123456789

Temporary Password:
9876Nsu

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

Address for Return Envelope:

DATA COLLECTION AGENCY
SURVEY STAFF
123 MAIN STREET
MY CITY, US 12345-0000

Your Establishment ID:

77-123456789-3

Your Company Address:

YOUR COMPANY NAME
987 YOUR STREET
YOUR CITY, US 98765-0000

NAICS code location.

- 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:

- ❑ Strike or lockout
- ❑ Shutdown or layoff
- ❑ Seasonal work
- ❑ Natural disaster or adverse weather conditions
- ❑ Shorter work schedules or fewer pay periods than usual
- ❑ Longer work schedules or more pay periods than usual
- ❑ Other reason: _____
- ❑ 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).

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 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:

Pay Period	Number of Employees Paid Per Pay Period
1	30
2	0
3	35
4	37
5	37
6	40
7	43
8	42
9	37
10	35
11	30
12	+26
	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
X 2,000	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
+ 2,716	part-time hours
61,516	total hours worked

Section 3: Reporting Cases

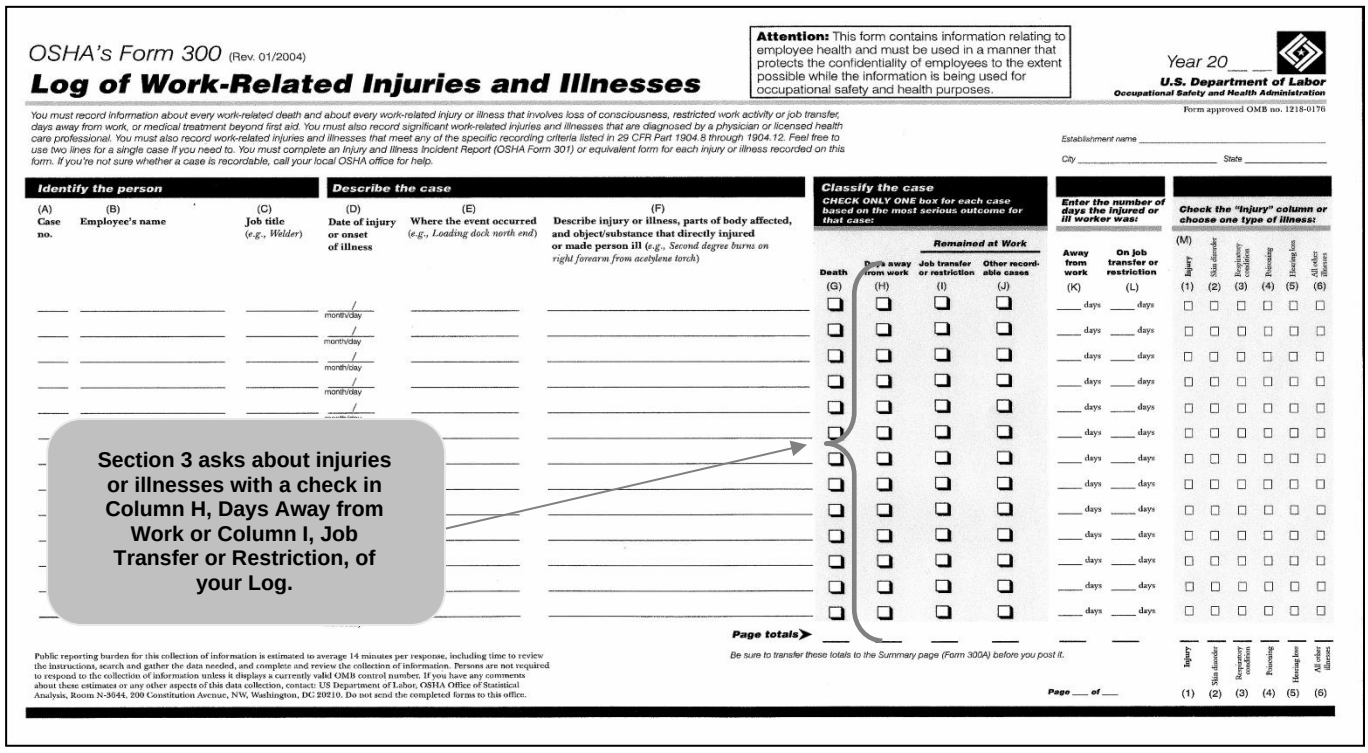
Instructions:

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.



Step 4: 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 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 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 *month day year*		

Tell us about the Employee

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

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

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 *month day year*	_____	_____

Tell us about the Employee

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

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

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.

	( ) -		( ) -
Printed name	*Telephone number*	*Ext.*	*Fax number*

	/ /
Title	*Today's date*

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