U.S. Department of Labor, Bureau of Labor Statistics

Survey of Occupational Injuries and Illnesses, 2010

Virgin Islands Fax Response Form
Send to (340) 777-4803

Employers selected for the BLS Survey of Occupational Injuries and Illnesses are required by Federal Law to respond. If you have questions please contact us at the phone number listed on the front of your survey instructions.

Section 1: Establishment Information

52 - _____ - _____ **Establishment ID Number** (from front of survey instructions)

Company Name and **Report For** (from front of survey instructions) **Today's Date**

_____ ___/___/___

Contact Name and Title (please print) **Telephone Number (ext)** **Fax Number**

_____ (___) ___ - ____ (___) ___ - ____

1 Enter the annual average number of employees for 2010. → _____

2. Enter the total hours worked by all employees for 2010. → _____

3. Did you have ANY work-related injuries or illnesses during 2010?
   - ❑ Yes → **Complete Section 2 below.**
   - ❑ No → **Please fax this form to (340) 777-4803.**

Section 2: Summary of Work-Related Injuries and Illnesses

1. Refer to the OSHA *Forms for Recording Work-Related Injuries and Illnesses* for the location referenced on the front of the survey instructions under Report For.
2. If you prefer, you may fax your *Summary of Work-Related Injuries and Illnesses* (OSHA Form 300A) with this form. If more than one establishment is noted on the front of the survey instructions, be sure to fax the OSHA Form 300A for each of the specified establishments.
3. If any total is zero on your OSHA Form 300A, write "0" in that 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)		(M)
(1) Injuries	_____	(4) Poisonings	_____
(2) Skin disorders	_____	(5) Hearing loss	_____
(3) Respiratory conditions	_____	(6) All other illnesses	_____

OMB No. 1220-0045
BLS-9300 FAX

Case with Days Away from Work

If you reported cases resulting in days away from work in Column H in Section 2 on Page 1, tell us about the 2010 work-related injuries or illnesses. One *Case with Days Away from Work* form should be completed for each injury or illness listed in Column H. Most of this information about the employee and the incident can be found on *OSHA Form 301*.

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)
		___/___/**10** *mm dd*		

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
- ❑ Other:_____
- ❑ Healthcare
- ❑ Delivery or driving
- ❑ Food service
- ❑ Cleaning, maintenance of building, grounds
- ❑ Material handling *(e.g.* stocking, loading/unloading, moving, etc.)
- ❑ 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:** _____/_____/_____ *mm dd yy*

4. **Employee's date hired:** _____/_____/_____ *mm dd yy*

***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: ❑ 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.

Thank you for your participation. Please fax your completed forms to (340) 777-4803.

For office use

N	P	S	E	SS	OCC