

# Survey of Occupational Injuries and Illnesses, 2025



## Virgin Islands Fax Response Form

**Fax to (340) 715-5740 or email to VirginIslands-SOII-Help@bls.gov**

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** (from front of survey instructions)

**Contact Name and Title** (please print)

**Today's Date**

**Contact Email Address** (please print)

**Telephone Number (ext)**

**Fax Number**

1 Enter the annual average number of employees for 2025.

2 Enter the total hours worked by all employees for 2025.

3 Did you have ANY work-related injuries or illnesses during 2025?

☐ Yes → **Complete Section 2 below.**

☐ No → **Please fax this form to (340) 715-5740 or email VirginIslands-SOII-Help@bls.gov**

### 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)

(1) Injuries

(2) Skin disorders

(3) Respiratory conditions

(4) Poisonings

(5) Hearing loss

(6) All other illnesses

# Injury and Illness Case Form

If you had cases in 2025 with days away from work (Column H in Section 2 on Page 1) or days of job transfer or restriction (Column I in Section 2 on Page 1), please complete one *Injury and Illness Case Form* for each 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<br>(Column B) | Job title<br>(Column C) | Date of injury<br>or<br>onset of illness<br>(Column D) | Number of days<br>away from work<br>(Column K) | Number of days<br>of job transfer<br>or restriction<br>(Column L) |
|-------------------------------|-------------------------|--------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------|
| _____                         | _____                   | ____/____/25<br><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.

Thank you for your participation.

Please fax your completed forms to (340) 715-5740 or email to [VirginIslands-SOII-Help@bls.gov](mailto:VirginIslands-SOII-Help@bls.gov)