Wisconsin Fax Response Form
Send to (608) 221-6297

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**

55 - [Establishment ID Number] - [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 2018.  

2. Enter the total hours worked by all employees for 2018.  

3. Did you have ANY work-related injuries or illnesses during 2018?  

   - [ ] Yes → Complete Section 2 below.  
   - [ ] No → Please fax this form to (608) 221-6297.

**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).

<table>
<thead>
<tr>
<th>Number of Cases</th>
<th>Total number of deaths</th>
<th>Total number of cases with days away from work</th>
<th>Total number of cases with job transfer or restriction</th>
<th>Total number of other recordable cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>(G)</td>
<td>(H)</td>
<td>(I)</td>
<td>(J)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Total number of days away from work</th>
<th>Total number of days of job transfer or restriction</th>
</tr>
</thead>
<tbody>
<tr>
<td>(K)</td>
<td>(L)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Injury and Illness Types</th>
<th>(M)</th>
<th>(N)</th>
<th>(O)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Injuries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Skin disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Respiratory conditions</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(4) Poisonings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) Hearing loss</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6) All other illnesses</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Tell us about the Case**

Go to your completed OSHA Form 300. Copy the case information from that form into the spaces below.

<table>
<thead>
<tr>
<th>Employee’s name (Column B)</th>
<th>Job title (Column C)</th>
<th>Date of injury or onset of illness (Column D)</th>
<th>Number of days away from work (Column K)</th>
<th>Number of days of job transfer or restriction (Column L)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>/ 18 month / day / year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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:____________________

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: _____/_____/_____
   - 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 (608) 221-6297.