partment of Labor

For Calendar Year 19 _____ Page ____ of ____

Form Approved
O.M.B. No. 1220-0029
See OMB Disclosure Statement on reverse.

t Name

nt Address

d Outcome of INJURY

Nonfatal Injuries				
Injuries With Lost Workdays				Injuries Without Lost Workdays
Enter a CHECK if injury involves days away from work, or days of restricted work activity, or both. (2)	Enter a CHECK if injury involves days away from work. (3)	Enter number of DAYS *away from work.* (4)	Enter number of DAYS of *restricted work activity.* (5)	Enter a CHECK if no entry was made in columns 1 or 2 but the injury is recordable as defined above. (6)

Type, Extent of, and Outcome of ILLNESS

Type of Illness								Fatalities	Nonfatal Illnesses				
CHECK Only One Column for Each Illness *(See other side of form for terminations or permanent transfers.)*								Illness Related	Illnesses With Lost Workdays				Illnesses Without Lost Workdays
Occupational skin diseases or disorders	Dust diseases of the lungs	Respiratory conditions due to toxic agents	Poisoning (systemic effects of toxic materials)	Disorders due to physical agents	Disorders associated with repeated trauma	All other occupational illnesses		Enter DATE of death. Mo./day/yr.	Enter a CHECK if illness involves days away from work, or days of restricted work activity, or both.	Enter a CHECK if illness involves days away from work.	Enter number of DAYS *away from work.*	Enter number of DAYS of *restricted work activity.*	Enter a CHECK if no entry was made in columns 8 or 9.
(7)								(8)	(9)	(10)	(11)	(12)	(13)
(a)	(b)	(c)	(d)	(e)	(f)	(g)							

INJURIES

ILLNESSES

ion of Annual Summary Totals By _____ Title _____ Date _____

o 200

POST ONLY THIS PORTION OF THE LAST PAGE NO LATER THAN FEBRUARY 1.