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# MIOSHA

Michigan Occupational Safety and Health Administration  
Department of Labor and Economic Opportunity (LEO)

# AGENCY INSTRUCTION

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DOCUMENT IDENTIFIER:

MIOSHA-ADM-15-6R3

DATE:

January 24, 2022

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**SUBJECT: Injury and Illness (I&I) Report Processing**

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- I. Purpose. This instruction provides procedures for processing reports required by the new injury and illness reporting requirements in MIOSHA Administrative Standard Part 11, /R 408.22101 *et seq.*, Recording and Reporting of Occupational Injuries and Illnesses. This instruction covers: (1) intake of reports, (2) initial entry of reports into a new MIOSHA Injury and Illness (I&I) Database, (3) initial distribution of reports, (4) evaluation of reports by the enforcement divisions, (5) evaluation of reports by the Consultation Education and Training (CET) Division, (6) OSHA Information System (OIS) entry, and (7) recording the status of the reports in the MIOSHA I&I Database.
- II. Scope. This instruction applies to the Construction Safety and Health Division (CSHD), the CET Division, the General Industry Safety and Health Division (GISHD), and the Technical Services Division (TSD).
- III. References.
  - A. 29 CFR Part 1904.39, Reporting fatalities, hospitalizations, amputations, and losses of an eye as a result of work-related incidents to OSHA; September 18, 2014 Federal Register Vol. 79, No. 181, p. 56130.
  - B. Agency Instruction MIOSHA-STD-05-2, [Recording and Reporting of Occupational Injuries and Illnesses](#), as amended.
  - C. [MIOSHA Field Operations Manual \(FOM\)](#), as amended.
  - D. MIOSHA Administrative Standard Part 11, /R 408.22101 *et seq.*, [Recording and Reporting of Occupational Injuries and Illnesses](#).
- IV. Distribution. MIOSHA Staff; Federal OSHA; S-drive Accessible; and MIOSHA Messenger.
- V. Cancellations. All previous versions of this agency instruction.
- VI. Next Review Date. To be reviewed five (5) years after the date of issuance.
- VII. History. History of previous versions include:

MIOSHA-ADM-15-6R2, September 25, 2019  
MIOSHA-ADM-15-6R1, May 30, 2017  
MIOSHA-ADM-15-6, August 18, 2015
- VIII. Contacts. [Lawrence Hidalgo](#), Jr., Director, CSHD, [Adrian Rocskay](#), Director, GISHD, [Nella Davis-Ray](#), Director, CET, and [Ronald Ray](#), Director, TSD.
- IX. Originator: Barton G. Pickelman, Director
- X. Background. On September 18, 2014, OSHA issued a final rule revising its occupational injury and illness recordkeeping and reporting regulation at 29 CFR 1904. The new

requirements became effective at the federal level on January 1, 2015. On May 27, 2015, MIOSHA revised the recordkeeping and reporting rules in response to OSHA's September 18, 2014, final rule. The recordkeeping regulation revision requires employers to report all work-related in-patient hospitalizations, as well as amputations, and losses of an eye to MIOSHA within 24 hours of the event. The new reporting requirements will have a significant impact on MIOSHA enforcement activities. A large increase in the number of workplace incident reports to MIOSHA is anticipated.

Please note that the existing requirement in MIOSHA Administrative Standard Part 11, Recording and Reporting of Occupational Injuries and Illnesses, requiring employers to report work-related fatalities to MIOSHA within eight hours has not changed. However, employers are no longer required to report within eight hours the in-patient hospitalization of three or more employees as a result of a work-related incident. Instead, employers must report within 24 hours the inpatient hospitalization of one or more employees.

XI. Intake of Reports.

A. TSD Management Information Systems Section (MISS) will serve as the initial contact for the reporting employers who telephone or report in person. Also, at least two times per business day, MISS will monitor for reports submitted via the online form on the MIOSHA website, and reports submitted via the toll-free telephone voice mailbox. MISS will use the questionnaire/script in [Appendix A](#) to aid in the collection of the information. The following information is required to be reported:

1. The establishment name
2. The location of the work-related incident
3. The time of the work-related incident
4. The type of reportable event (i.e., in-patient hospitalization, amputation, or loss of an eye)
5. The number of employees who suffered in-patient hospitalization, amputation, or loss of an eye
6. The names of the employees who suffered in-patient hospitalization, amputation, or loss of an eye
7. The contact person and his or her phone number
8. A brief description of the work-related incident
9. Whether or not the incident resulted from construction activity
10. The name and phone number of the person who reported the incident

B. The online form for employers who report via the MIOSHA website is described in [Appendix B](#). An employer will not be able to report a fatality via this online form. If an employer attempts to report a fatality using the on-line form, the

employer will be prompted to call the MIOSHA toll-free central telephone number (1-800-858-0397).

- XII. Initial Entry into the MIOSHA I&I Database. When MISS receives a report of an in-patient hospitalization, amputation, or loss of an eye, MISS will evaluate whether the incident was work-related, in accordance with current OSHA directives and letters of interpretation affecting the regulation. If the report is work-related, MISS will enter the information into the MIOSHA I&I Database. If all the required information is not provided, MISS will contact the employer or attempt to contact the employer at least twice to obtain the information. If MISS cannot obtain the required information after attempting to do so, this will be noted in the MIOSHA I&I Database and the report will be distributed as is.
- XIII. Initial Distribution of Reports. MISS will complete a one-page report form ([Appendix C](#)) and send it to a primary and/or backup person in either CSHD or GISHD. If the incident resulted from construction activity, MISS will send the completed report form to CSHD. If the incident did not result from construction activity, MISS will send the report form to GISHD. If MISS cannot determine whether the incident was related to construction work or general industry, then MISS will send the report form to GISHD.
- XIV. Modification of Intake Information. If employers call back to modify or retract their reports, MISS staff will amend the MIOSHA I&I Database accordingly. Modifications and retractions of reports already distributed to CSHD or GISHD will result in reprints of the reports. In both cases, the reports will inform CSHD and GISHD of the changes. CSHD and GISHD will take the appropriate action to handle the modified or retracted reports.
- XV. CSHD and GISHD Evaluation of Reports. The appropriate enforcement division will evaluate each report and other available information and exercise professional judgment to determine whether or not an on-site or off-site inspection will be conducted. If an on-site or off-site inspection will not be conducted, the report will be forwarded to CET to be evaluated.
- XVI. CET Evaluation of Reports. Reports forwarded to CET from CSHD and GISHD that are not assigned for an inspection may still have workplace safety and/or health concerns. CET will assess those reports and prioritize them as appropriate. All reports from current Michigan Voluntary Protection Program (MVPP), Michigan Safety & Health Achievement Recognition Program (MSHARP), or MIOSHA Challenge Program (MCP) participants will be assigned to CET staff for follow-up. At a minimum, CET will offer assistance to each employer not assigned for an inspection. CET's goal is to encourage proactive communication and to connect with employers who report their incidents under the new reporting requirements. The employer's email address (if provided) will also be added to the MIOSHA GovDelivery subscription lists to receive the quarterly MIOSHA News, the monthly MIOSHA eNews, and regular CET messages.
- XVII. OIS Entry. If an inspection (on- or off-site) will be conducted, the information must be manually entered into OIS. A report will be entered as an unprogrammed activity (UPA). The UPA will be recorded as "Referral – Employer Reported = Yes." Note that reports of

work-related fatalities and catastrophes will still be entered as “FAT/CAT.” Catastrophes, which are defined as three or more hospitalizations, will remain within the “FAT/CAT” category, but employer-reported hospitalizations of two or fewer will be recorded as “Referral – Employer Reported = Yes.” See [Appendix D](#) for screenshots and instructions on how to enter reports.

XVIII. Recording the Status of the Reports in the MIOSHA I&I Database.

A. CSHD or GISHD, as appropriate, must enter the following information into the MIOSHA I&I Database:

1. Whether an on-site or off-site inspection was conducted, or the report was forwarded to CET.
2. The UPA number, if the report was entered into OIS.
3. The inspection number, if an on-site inspection was conducted.
4. The date the report was forwarded to CET if an on-site or off-site inspection was not conducted.

Note: The identification (ID) number of the CSHD or GISHD person who accesses the database to enter information is automatically entered into the database.

The date the report was received in CSHD or GISHD is automatically entered into the database when MISS sends the report.

B. CET must enter the following information into the MIOSHA I&I Database whether CET:

1. Assigned the report for follow-up.
2. Contacted the employer and offered assistance along with adding employer’s email address (if provided) to the MIOSHA GovDelivery subscription lists.

Note: The ID of the CET person who accesses the database to enter information is automatically entered into the database.

The date the report was received in CET is automatically entered into the database when CSHD or GISHD sends the report.

## Appendix A

### Amputation, Loss of Eye, and Hospitalization - Employer Report Questionnaire

Obtain information from the caller by asking the following questions. Items identified with an asterisk are required pieces of information.

#### Questions about the incident.

1. Are you calling to report an in-patient hospitalization, amputation, or loss of an eye? If no, clarify to the caller what types of injuries/illness require reporting vs. recording.
2. **Was the injury related to the use of a mechanical power press?** If the injury was related to the use of a mechanical power press, EVEN IF IT WAS NOT AN AMPUTATION, INPATIENT HOSPITALIZATION OR LOSS OF EYE, the employer is required to report this to MIOSHA. For injuries that fall under the defined severe injuries, we will take the report and ask additional questions pertaining to the mechanical power press operation. For injuries that do not meet the reportable standard we will transfer them to GISHD (517-284-7750).
3. Are you calling to report a fatality? If yes, direct caller to either GISHD (517-284-7750) or CSHD (517-284-7680) main number and transfer call. Inform the caller that they will be transferred one additional time to the appropriate staff within the division.
4. \*Is this a work-related incident?
5. Are you authorized to submit this injury and illness information to MIOSHA on behalf of the employer? If not, redirect the caller to the online complaint form or provide contact information for the appropriate division.
6. \*What is your name and title, and what is the best phone number and email address to reach you?
7. In addition to reporting the incident, are you also an employer contact with whom we can follow up for additional information?
8. \*Was the injured employee(s) working in construction or general industry?
9. \*What date did the incident occur?
10. \*What time did the incident occur?
11. \*Please provide a brief description of the work-related incident.
12. Was the injured employee(s) a temporary worker?
13. Has the hazard, that directly caused the harm to the injured employee(s), been removed from the workplace?
14. If the answer to the previous question was yes, what steps were taken to remove the hazard?

**The next seven questions are only asked if the injury was related to the use of a mechanical power press.**

- a) What operation was being performed: setup, maintenance, or another task?
  - b) What was the type of clutch used on the press: full revolution, part revolution, or direct drive?
  - c) What type of safeguard was being used on the press: 2-hand control, 2-hand trip, pull-outs, or other?
  - d) What was the cause of the accident: repeat of the press, safeguard failure, removing stuck part/scrap, no safeguard provided, no safeguard in use, other?
  - e) How were the parts being loaded into the press: by the employees' hands (manually) or an automatic feed?
  - f) How was the press actuated/cycled: foot trip, foot control, hand trip, hand control, or other?
  - g) How many employees were operating the press?
  - h) Did the operators each have a set of controls to cycle the press?
15. Is there any additional information you would like to provide about the incident?
16. \*What is the location name and address where the incident occurred?

**Questions about the injured employee(s) – Ask for each injured employee being reported.**

17. \*What is the name of the injured employee?
18. What is the employee's title?
19. What was the employee doing just before they were injured or became ill? For example, what type of equipment was being used or what operation was being performed?
20. What part of the employee's body was injured (e.g., the employee's right arm below the elbow)?
21. What was the type of injury or illness (e.g., chemical burn, laceration, poisoning, inhalation of toxic substance)?
22. What object or substance directly harmed the employee (e.g., bandsaw blade, carbon monoxide)?
23. \*Note: If not specifically evident from answers to questions 19 - 21, did the employee sustain an amputation, loss of an eye, and/or receive in-patient hospitalization?
24. Were there any other employees with severe injuries as a result of this incident? Note: If the answer is yes, go to question 16 for the next employee; if no, go to question 24.
25. \*I show there were a total of XX employees injured as a result of this incident, is that correct?

**Questions about the employer.**

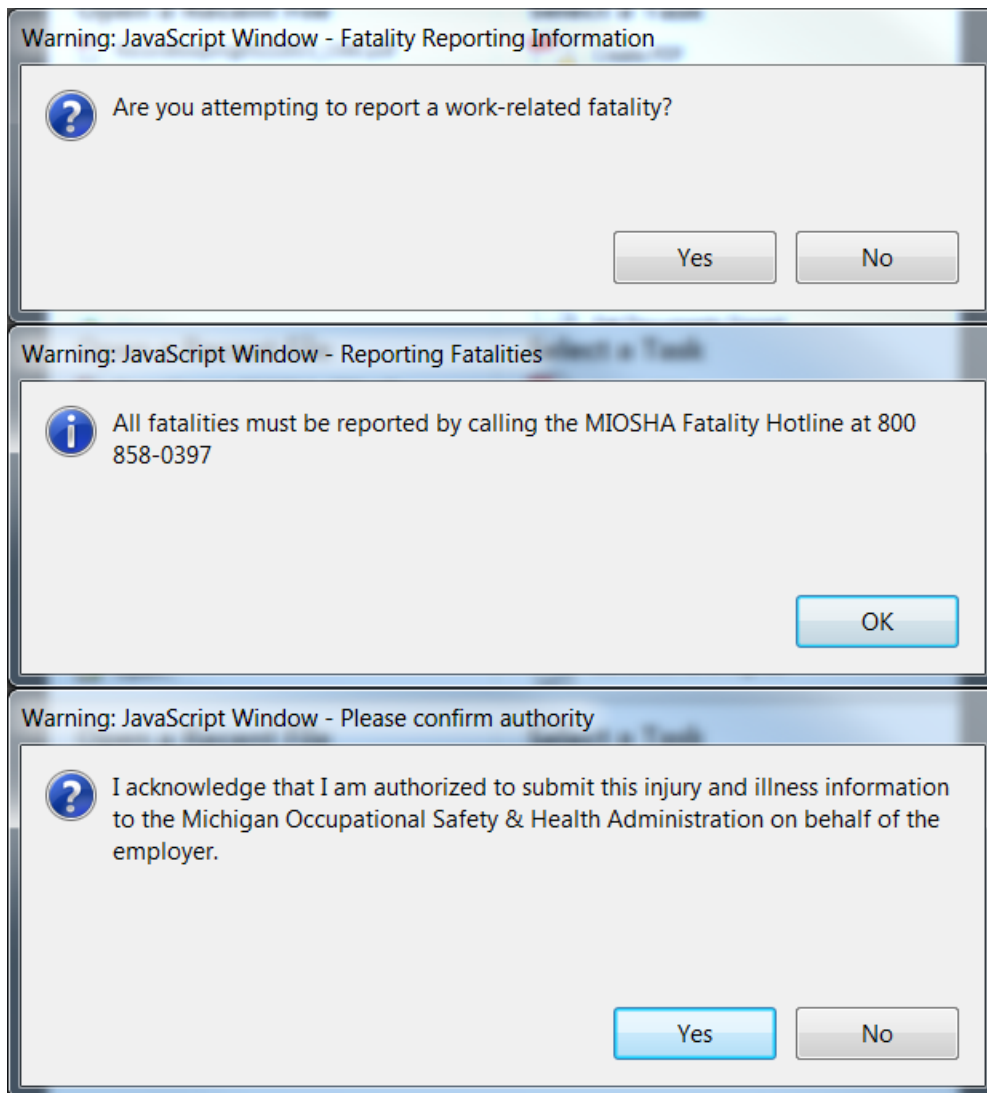
26. \*What is the employer establishment/business name for the injured employee?
27. What is the employer's address? If the employer gives an out of state business address, staff will ask the employer if they can provide an in-state address, such as an area office. If the employer cannot provide an in-state address staff will record the out of state address in the database.

**Questions about employer contacts (ask for each contact) Note: If the submitter is also a contact, the following questions may not be applicable. The submitter can provide additional contacts (and must if they themselves are not a contact).**

28. \*What is the first name and last name of the employer contact person?
29. What is the contact's title?
30. What is the contact's email address?
31. \*What is the best phone number to reach the contact?
32. Are there any additional people to record as contacts for this incident?

**Appendix B**  
**MIOSHA Online Hospitalization, Amputation,  
Loss of Eye Injury & Illness Reporting Form**

The online form appears in data flow segments, guiding the users through a segment at a time. The screenshots below show the parts of the form and user prompts provided for guidance. The initial user prompts are safeguards to ensure the user is not attempting to report a fatality through this form, and that they are authorized to report for the employer.



|                   |                                       |   |
|-------------------|---------------------------------------|---|
| Submission Number | 1438107374                            |   |
| *Employer Type    | <input type="checkbox"/> Construction | <input type="checkbox"/> General Industry |



## Michigan Occupational Safety and Health Administration Employee Injury/Illness Incident Report

This form is to be used by Michigan employers to report work-related employee incidents that result in the loss of an eye, an amputation, or inpatient hospitalization within 24 hours of the incident. Required fields are indicated by \* and outlined in red. If you have questions about filling out this form please call (844) 464-6742.

Failure to provide complete and accurate information in the required fields may be a violation of MIOSHA Administrative Standard Part 11, Recording and Reporting of Occupational Injuries and Illnesses.

Work-related Fatalities must be reported by calling (800) 858-0397.

### Submitter Information

|  |                      |            |   |
|--|----------------------|------------|---|
| *First Name  | <input type="text"/> | *Last Name | <input type="text"/>                    |
| Title  | <input type="text"/> | Email      | <input type="text"/>                    |
| *Contact Phone   | <input type="text"/> | Cell Phone | <input type="text"/>                    |
| <input type="checkbox"/> Please check if you are an employer contact |                      |            | <input type="button" value="Continue"/> |

### Incident Information

|  |                              |                             |                      |
|--|------------------------------|-----------------------------|----------------------|
| *Date of Incident  | <input type="text"/>         | *Time of Incident           | <input type="text"/> |
| *Brief description of the work-related incident:                 | <input type="text"/>         |                             |                      |
| Was one or more of the injured/ill employees a temporary worker? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                      |
| Has the hazard that caused the injury/illness been removed?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                      |
| Additional Information   | <input type="text"/>         |                             |                      |

### Incident Location

\*Location of the work-related incident

Street Address Line 1

Street Address Line 2

City

State

County

Zip Code  GPS Coordinates

Continue

### Injured/Ill Employee

\*First Name  \*Last Name

Job Title

Indicate below what the injured employee was doing just before they became injured/ill; what work activity and tools, equipment or materials were being used; what happened?

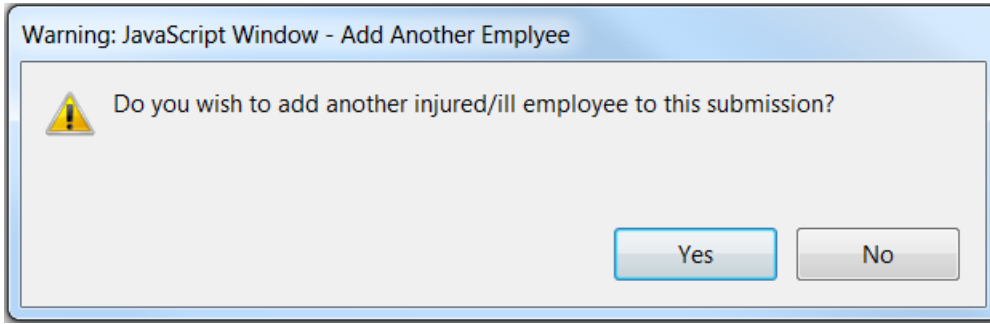
Indicate below the part of the body that was injured (e.g. right arm from elbow to hand, left eye, left side of body from shoulder to waist, etc.).

Indicate below the type of injury to employee (e.g. chemical burn, laceration, contusion, etc.).

Indicate below what object or substance directly harmed the employee.

\*Select at least one of the following resulting from the injury/illness  Inpatient Hospitalization  Amputation  Loss Of An Eye

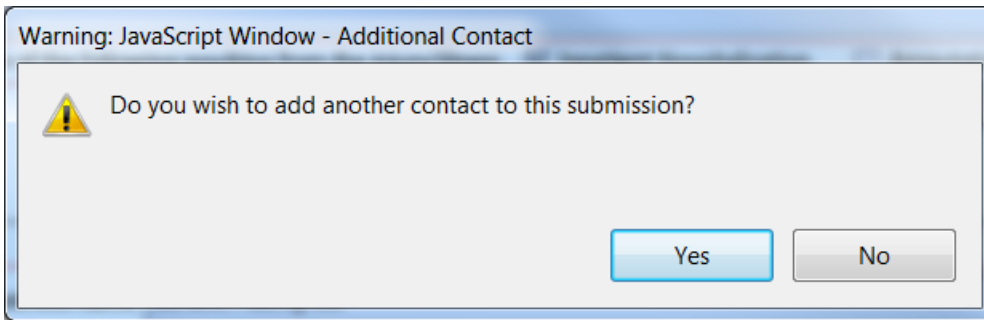
Continue



### Employer Information

|   |                      |
|---|----------------------|
| *Establishment/Business Name            | <input type="text"/> |
| Other Name                              | <input type="text"/> |
| Street Address Line 1                   | <input type="text"/> |
| Street Address Line 2                   | <input type="text"/> |
| City                                    | <input type="text"/> |
| State                                   | MI                   |
| Zip Code                                | <input type="text"/> |
| <input type="button" value="Continue"/> |                      |

If the submitter is checked as a contact, the following message will pop up BEFORE the contact form.




### Contact Information


|   |                      |               |                      |
|---|----------------------|---------------|----------------------|
| *First Name                             | <input type="text"/> | *Last Name    | <input type="text"/> |
| Title                                   | <input type="text"/> | Email Address | <input type="text"/> |
| *Contact Phone                          | <input type="text"/> | Cell Phone    | <input type="text"/> |
| <input type="button" value="Continue"/> |                      |               |                      |

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Warning: JavaScript Window - Injured/Ill Employee Count

 You have reported 1 injured/ill employees for this submission. Is this correct?

Warning: JavaScript Window - Acknowledge Submission Responsibility

 By continuing, you acknowledge your responsibility for submitting any knowingly false information pursuant to Michigan Compiled Laws rule 408.1035(7). Do you accept this responsibility?

1432644399 - Message (Plain Text)

File Message Insert Options Format Text Review Adobe PDF SecureZIP

Cut Copy Paste Format Painter Clipboard Basic Text Address Book Check Names Attach File Attach Item Signature Follow Up High Importance Low Importance Tags Zoom

From: Microsoft Exchange Server

To: MIOSHA I & I Reporting MIOSHA I & I Mailbox

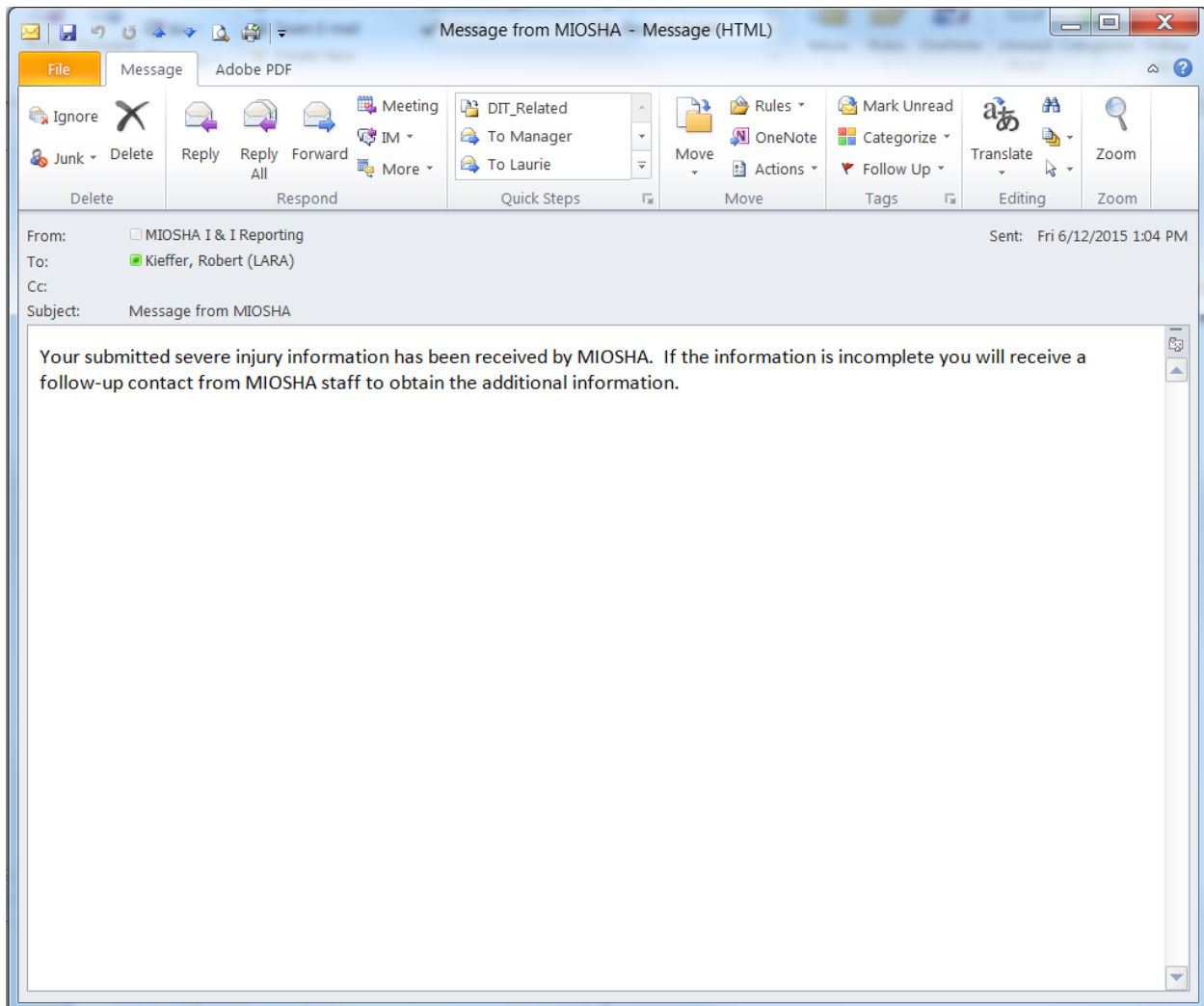
Cc:

Subject: 1432644399 Unique Submission number

Attached: RecordKeeping05222015\_1700\_data.xml (3 KB)


If you have any questions, please call the MIOSHA Injury and Illness Hotline at (844) 464-6742.

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The above auto-reply email will be sent out to employers emailing their online form data.

### Appendix C Sample Report Form

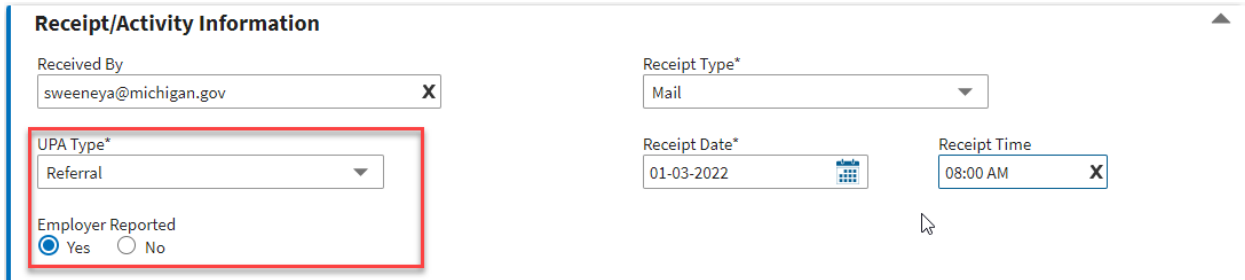
|                                 |                                  |  |   |                                |          |   |
|---------------------------------|----------------------------------|--|---|--------------------------------|----------|---|
| <b>General Industry</b>         |                                  | <b>MIOSHA Severe Injury Report</b>   |   | # Injured Workers              | <b>1</b> |  |
| Intake: <b>On-Line</b>          | Disposition: <b>Sent to Unit</b> |  | IncidentID: <b>316</b>  |                                |          |   |
| IncidentDate: <b>6/11/2015</b>  | SubmitDate: <b>12/6/2015</b>     | Submitted: <input checked="" type="checkbox"/>   | ReportDate: <b>12/6/2015</b>                                  |                                |          |   |
| IncidentTime: <b>2:30:00 AM</b> | SubmitTime: <b>4:21:00 PM</b>    | Complete: <input type="checkbox"/>   | ReportTime: <b>4:35:00 PM</b>                                 |                                |          |   |
| <b>Location Address</b>         |                                  | <b>Incident Detail</b>   |   |                                |          |   |
| Power Plant #37                 |                                  | What Happened?<br>Just a usual day. Crew of 10 working afternoon shift. Workers reported feeling tremors, maybe an earth quake. Foreman at first wasn't convinced and then came to the plant floor and felt the shaking. He ordered everyone out of the building. People were running out and made it safely away except one. The power plant collapsed into a sink hole that opened up. One employee had to be extracted out of the collapsed building. |   |                                |          |   |
| 234 Skiddoo                     |                                  |  |   |                                |          |   |
| <b>P.O. Box 12</b>              |                                  | <b>Additional Info</b>   |   |                                |          |   |
| Cassopolis                      | MI                               | 32412  | additional input  |                                |          |   |
|                                 |                                  | TempWorker: <input checked="" type="checkbox"/>  | Haz. Removal Description: <input checked="" type="checkbox"/> | sink hole covered up and paved |          |   |
| <b>BusinessName Address</b>     |                                  | <b>OtherName</b>   |   |                                |          |   |
| Generic Manufacturing Inc.      |                                  | Less Descriptive Manufacturing   |   |                                |          |   |
| 2321 Appian Way                 |                                  |  |   |                                |          |   |
| Suite 125                       |                                  |  |   |                                |          |   |
| Laingsburg                      |                                  | MI   | 48821   |                                |          |   |
| <b>Injured Employees</b>        |                                  | <b>Hospital</b>  |   | <b>Amputation</b>              |          | <b>Eye</b>  |
| Emp. Name                       | Willy Sycamore                   | <input checked="" type="checkbox"/>  |   | <input type="checkbox"/>       |          | <input type="checkbox"/>  |
| What emp. was doing             | operating plant                  |  |   |                                |          |   |
| Body part(s) affected           | head                             |  |   |                                |          |   |
| Injury Type                     | contusion                        |  |   |                                |          |   |
| Object causing injury           | collapsing roof                  |  |   |                                |          |   |

|                       |                        |                                     |                       |                          |
|-----------------------|------------------------|-------------------------------------|-----------------------|--------------------------|
| <b>Submitted by</b>   |                        |                                     |                       |                          |
| <b>Submitter Name</b> | <b>Submitter Title</b> | <b>Submitter WPhon</b>              | <b>SubmitterEmail</b> | <b>Not a Contact</b>     |
| ann smith             | hr                     | (322) 433-5544                      |                       | <input type="checkbox"/> |
| <b>NoteDate</b>       |                        |                                     |                       |                          |
| <b>UserNote</b>       |                        |                                     |                       |                          |
| 6/10/2015             | kiefferr1              | This is a test of the note section. |                       |                          |

## Appendix D

### Sample OIS Screenshots for Employer-Reported Referrals in OIS

1. When **Activity Type** is *Referral*, then the **Employer Reported** box will appear. A *Yes* or *No* selection is then required.



**Receipt/Activity Information**

Received By:  X

Receipt Type\*:

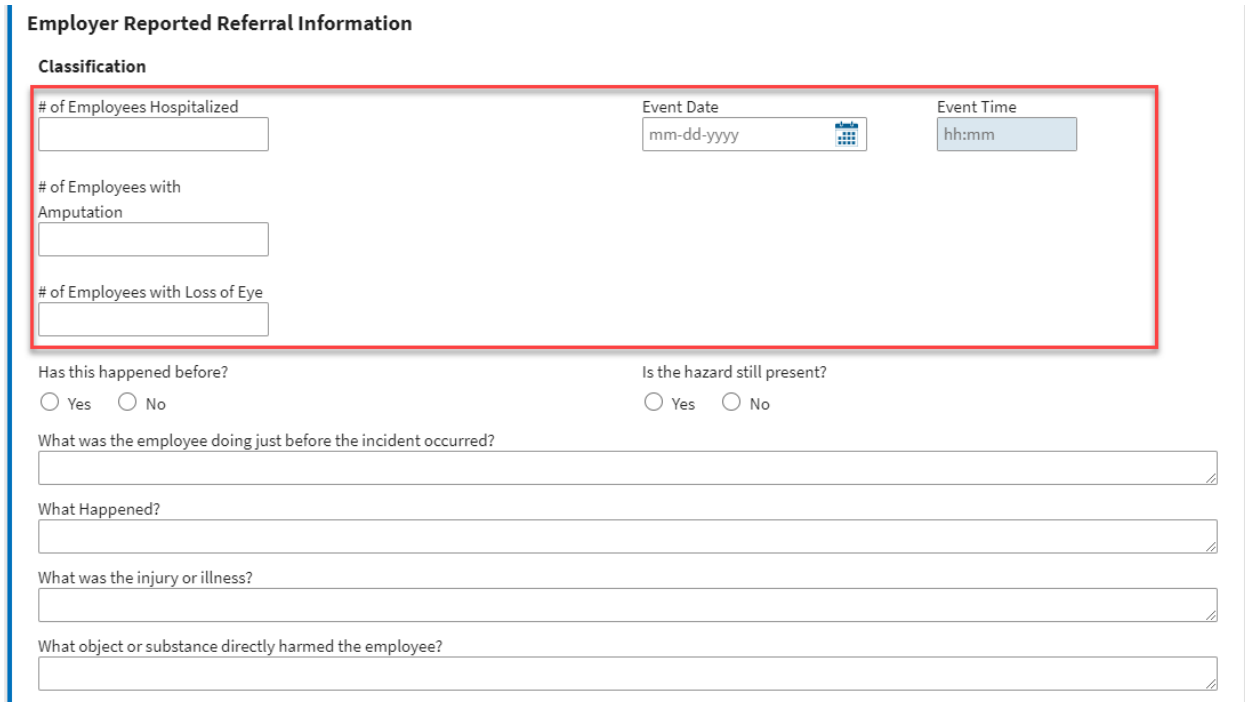
UPA Type\*:

Receipt Date\*:

Receipt Time:  X

Employer Reported  
 Yes  No

2. If the selection for the **Employer Reported** field is *Yes*, then additional required fields become enabled at the bottom of the tab.



**Employer Reported Referral Information**

**Classification**

# of Employees Hospitalized:

Event Date:

Event Time:

# of Employees with Amputation:

# of Employees with Loss of Eye:

Has this happened before?  
 Yes  No

Is the hazard still present?  
 Yes  No

What was the employee doing just before the incident occurred?

What Happened?

What was the injury or illness?

What object or substance directly harmed the employee?

3. If the selection for the **Initiating Type** field is *Referral–Employer Reported*, and an on-site inspection is conducted, the **Initiating Type** field under the **Inspection Type** sub-tab is *Referral–Employer Reported*.

**Injured Employee Information**

|  |  |
|--|--|
| First Name*                                  | Last Name*   |
| <input type="text"/>                         | <input type="text"/>                                     |
| Age  | Sex  |
| <input type="text"/>                         | <input type="radio"/> Male <input type="radio"/> Female  |
| Employment Type                              |  |
| Select                                       |  |
| Occupation                                   | Injury   |
| <input type="text"/>                         | <input type="text"/>                                     |
| Location to which Injured Employee was moved | Worker's Compensation Insurance Carrier (Name & Address) |
| <input type="text"/>                         | <input type="text"/>                                     |
| Street Address 1                             | Street Address 2   |
| <input type="text"/>                         | <input type="text"/>                                     |
| Country                                      | State  |
| UNITED STATES OF AMERICA X                   | Search...  |
| City   | County   |
| Search...                                    | Search...  |
| Zip Code                                     |  |
| Search...                                    |  |
| Phone  |  |
| US XXX-XXX-XXXX                              |  |
| Extn   |  |
| <input type="text"/>                         |  |

✓ ✗

## Inspection

**Inspection Data**

Related Activities

- + Related UPA
- + Related Inspection

Inspection Details

|                            |
|----------------------------|
| Initiating Type            |
| Referral-Employer Reported |

From the Inspection Case Summary page, click Add Investigation.

Inspection #987963 Health Sampling Violation Documents

Inspection Case Summary #987963

Add Investigation