

**Iowa Division of Labor OSHA
Enforcement**

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FOR OFFICE USE ONLY

Received by: _____
Sent by: Fax Phone Email
Date: _____ Time: _____
Inspection planned: Yes No
Inspection #: _____ CSHO: _____
Autopsy performed: Yes No

Employer Incident Report Form

Enter # of affected employees: Fatality Hospitalization Loss of an eye Amputation

Business name		Federal ID #	NAICS	Total employees	
Mailing address		City		State	Zip
Phone	Fax	Business activity			
Ownership: Private	Local Government	State Government	Federal Agency	Union?	Yes No
Your name (employer representative)		Job title			
Phone number	Fax number	Email address			
Event address	Same as mailing address		City	State	Zip
Victim's name	Age	Occupation			
Employee type: Current	Temporary	Accident date	Accident time		
Description of incident					

Fatality next of kin information

Name	Relationship	Phone number	
Mailing address	City	State	Zip