**Wisconsin State Laboratory of Hygiene**

**Occupational Safety and Health Statistics**

**Census of Fatal Occupational Fatalities (CFOI) – Case Fatality Form**

**2810 Walton Commons Ln #200 Madison, WI 53718**

**Phone: 608-221-6289 Fax: 608-221-6297**

**Demographics**

Decedent’s name: Gender: Male Female

Date of Birth: \_\_ \_\_ - \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ Social Security Number: \_\_ \_\_ \_\_ - \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

**Employer Information**

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was Decedent Self-Employed? Yes No

**Incident**

Date of the Injury/Illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State of Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time of Injury/Illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the employee doing just before the incident?

What happened? (Briefly, but please include specifics; e.g., falls from height: include height and structure type.)

What object or substance directly caused the fatality? (If vehicle, please include type and safety belt usage.)

Where did the incident occur?

Is there an autopsy being conducted? Yes No Is there an inquest being conducted? Yes No

If “Yes,” date of autopsy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If “Yes,” approximate date of inquest: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Toxicology results (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Coroner’s Office**

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_