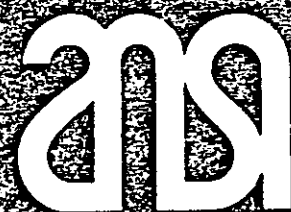


American National Standard

for uniform recordkeeping
for occupational injuries
and illnesses

ANSI Z16.4-1977



american national standards institute, inc.
1430 broadway, new york, new york 10018

ANSI®
Z16.4-1977

**American National Standard
for Uniform Recordkeeping
for Occupational Injuries
and Illnesses**

Secretariat

American Insurance Association
National Safety Council

Approved July 8, 1977

American National Standards Institute, Inc

American National Standard

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Foreword

(This Foreword is not a part of American National Standard for Uniform Recordkeeping for Occupational Injuries and Illnesses, Z16.4-1977.)

The Williams-Steiger Occupational Safety and Health Act of 1970 mandated a comprehensive method for recording and reporting work accident and illness experience. Congress felt that American National Standard Method of Recording and Measuring Work Injury Experience, Z16.1-1967 (R1973), had grown too sophisticated in its effort to assure uniformity of reporting and, in so doing, did not accurately reflect the actual industrial occupational accident and illness experience.

A study group was recruited by the American National Standards Institute which filed a detailed recommendation with the Secretary of Labor in August 1970,* and the Bureau of Labor Statistics-Occupational Safety and Health Administration (OSHA) Recordkeeping Requirements† were issued based upon this work. In 1975, American National Standards Committee Z16 on Standardization of Methods of Recording and Compiling Accident Statistics began work to render American National Standard Z16.1-1967 (R1973) compatible with the new reporting system. It was soon realized that what was needed was a national standard that would define and provide for uniform interpretation of OSHA-required recordkeeping plus rates that would be used by those industries that wished to convert to an "OSHA system," and for contest and award purposes.

Three rates have been selected: the incidence rate of total recordable cases (in which all recordable cases are counted); the incidence rate of death cases plus lost workday cases with days away from work (in which all recordable cases that resulted in death, plus lost workday cases with days away from work, are counted); and an incidence of lost workdays, which is a measure of severity.‡

Suggestions for improvement of this standard will be welcome. They should be sent to the American National Standards Institute, 1430 Broadway, New York, N.Y. 10018.

This standard was processed and approved for submittal to ANSI by American National Standards Committee on Standardization of Methods of Recording and Compiling Accident Statistics, Z16. Committee approval of the standard does not necessarily imply that all committee members voted for its approval. At the time it approved this standard, the Z16 Committee had the following members:

Harry W. Becker, Chairman
John Mark, Secretary

<i>Organization Represented</i>	<i>Name of Representative</i>
Aerospace Industries Association of America	M. L. Williams
American Association of State Compensation Insurance Funds	Ralph Langley
American Conference of Governmental Industrial Hygienists	Vernon E. Rose
American Council on Education	Donald Dedrick
American Federation of Labor & Congress of Industrial Organizations	(Representation Vacant)
American Gas Association	Philip S. Runge
American Hospital Association	William J. Van Cleve
American Hotel and Motel Association	W. G. Bohm
American Industrial Hygiene Association	Raymond E. Kary
American Insurance Association	David Curley
American Iron and Steel Institute	John A. Janous
American Mutual Insurance Alliance	Thomas F. Bresnahan

*Proposed National System for Uniform Recording and Reporting of Occupational Injuries and Illnesses, SR1, New York: American National Standards Institute, 1970.

†Recordkeeping Requirements under the Occupational Safety and Health Act of 1970. Washington, D.C.: U.S. Department of Labor, Occupational Safety and Health Administration, revised 1975.

‡Other rates can, of course, be derived from the given data.

<i>Organization Represented</i>	<i>Name of Representative</i>
American Paper Institute.	Burl E. McGarrahan
American Petroleum Institute.	E. G. Reneghan (Alt)
American Society of Mechanical Engineers	David Johnston
American Society of Safety Engineers	James D. Manney (Alt)
American Statistical Association	Harry J. Eiermann
American Transit Association	Arthur H. Christian
American Water Works Association.	F. W. Wischmeyer (Alt)
Associated General Contractors of America	(Representation Vacant)
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Association of School Business Officials	Herbert J. Scheuer (Alt)
Canadian Standards Association (Liaison)	Harry W. Becker
Electric Light and Power Group.	Arthur L. Schmuhl
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Forging Industry Association	R. Litster
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National Education Association.	Paul N. Rasmussen
National Electrical Manufacturers Association	(Representation Vacant)
National Restaurant Association	(Representation Vacant)
National Safety Council	Benjamin J. Cieslik
Portland Cement Association	T. C. Mather (Alt)
The Society of the Plastics Industry	S. A. Abercrombie
The Telephone Group	William H. Ziefel
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U.S. Department of the Army.	J. L. Recht
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Nixon deTarnowsky, Chairman
John Mark, Secretary

Maurice F. Bresnahan
Thomas F. Bresnahan
Benjamin J. Cieslik
L. H. Faulkingham
David Johnston
J. W. Pardee
D. E. Redmon

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American National Standard for Uniform Recordkeeping for Occupational Injuries and Illnesses

Introduction

The methods outlined in this standard for classifying cases are independent of workmen's compensation laws and rulings of workmen's compensation agencies but compatible with the recordkeeping requirements of the Bureau of Labor Statistics and Occupational Safety and Health Administration of the U.S. Department of Labor.

The fact that the employee or employer did not have control over the cause of a work-related case shall not be a criterion for excluding the case from being recorded under the provisions of this standard.

Thorough investigation of all factors relating to the occurrence of each reported work-related case is essential. Determination as to whether or not the case should be considered recordable under the provisions of this standard shall be based upon the evidence developed in such investigations. Unless there is a preponderance of evidence that the case did not result from the work activity or environment of employment, the case shall be considered a work-related case. (See the Appendix for suggestions as to factors to be considered.)

When the proper classification of, or the recordability of, a work-related case is in doubt, nine copies of a full report of the circumstances of the incident or illness, including all pertinent medical information, may be submitted to the American National Standards Institute, 1430 Broadway, New York, N.Y. 10018 for an advisory opinion by the Z16 Committee on Interpretations.

1. Scope, Purpose, and Application

1.1 Scope. This standard covers the definitions and guidelines necessary to maintain basic occupational illness and injury records and incidence rates suitable for statistical purposes that are compatible with the recordkeeping requirements of the Occupational Safety and Health Act of 1970.

1.2 Purpose. The purpose of this standard is to promote uniformity in recording, classifying, and reporting occupational illness and injuries as a means of evaluating programs designed to control such injuries and illnesses, and for contest and award programs.

1.3 Application. It is recommended that this standard apply to all records of occupational illness and injuries effective January 1, 1977.

2. Definitions

2.1 Employee. As used in this standard, any person engaged in activities for an employer from whom direct payment for services is received. Included are working owners and officers.

2.2 Exposure or Employee-Hours. The total number of hours worked by all employees, including those in operating, production, maintenance, transportation, clerical, administrative, sales, and other activities. (See A2.2 of the Appendix.)

2.3 Work Environment. The environment comprised by the physical location, equipment, materials processed or used, and the kinds of operations performed by an employee in the performance of his work, whether on or off an employer's premises.

2.4 Establishment. A single physical location where business is conducted or where services or industrial operations are performed.

2.5 First Aid. Any one-time treatment and subsequent observation of minor scratches, cuts, burns, splinters, and so forth, which do not require medical care even though provided by a physician or registered professional personnel.

2.6 Medical Treatment. Any treatment (other than first aid) administered by a physician or by registered professional personnel under the standing orders of a physician. (See A2.6 of the Appendix.)

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2.7 Work-Related Case. Any occupational injury suffered by an employee which results from a work accident or from an exposure involving a single incident in the work environment, and any illness caused by exposure to environmental factors associated with employment. (See A2.7 of the Appendix.)

2.7.1 Occupational Injury. Any injury such as a cut, fracture, amputation, etc, that results from a work accident or from an exposure involving a single incident in the work environment.

2.7.2 Occupational Illness. Any abnormal condition or disorder of an employee, other than one resulting from an occupational injury, caused by exposure to environmental factors associated with employment.

2.8 Recordable Case. Any work-related injury case requiring more than first aid, and all occupational illnesses. Recordable cases include: (See A2.8 of the Appendix.)

(1) Deaths, regardless of the time between occupational injury or illness and death

(2) All occupational illnesses

(3) All occupational injuries resulting in any of the following:

(a) Lost workdays — either days away from work or days of restricted work activity

(b) Medical treatment other than first aid

(c) Loss of consciousness

(d) Restriction of work or motion

(e) Temporary or permanent transfer

(f) Termination of injured or ill employee

NOTE: Any case that involves lost workdays must be recorded since it always involves one or more of the criteria for recordability.

2.9 Lost Workdays¹

2.9.1 Lost Workdays — Days Away from Work.

Days away from work are those workdays (consecutive or not) on which the employee would have worked but could not because of occupational injury or illness. The number of lost workdays should not include the day of injury or onset of illness or any days on which the employee would not have worked even though able to work.

2.9.2 Lost Workdays — Days of Restricted Work Activity. Days of restricted work activity are those workdays (consecutive or not) on which, because of the occupational injury or illness, the employee was assigned to another job on a temporary basis, worked at a permanent job less than full time, or worked at a permanently assigned job but could not perform all

duties normally connected with it. The number of lost workdays should not include the day of injury or onset of illness or any days on which the employee would not have worked even though able to work.

2.10 Lost Workday Case. Any recordable case that results in lost workdays away from work or workdays of restricted activity.

2.10.1 Lost Workday Case with Days Away from Work. Any recordable case that results in 1 or more days away from work as defined in 2.9.1. (See A2.10.1 of the Appendix.)

2.10.2 Lost Workday Case with Days of Restricted Work Activity. Any recordable case that results in 1 or more days of restricted work activity as defined in 2.9.2. (See A2.10.2 of the Appendix.)

3. Date of Recordability

3.1 Occupational Injuries. The date of recordability for occupational injuries is the date on which the work accident or single incident exposure occurred.

3.2 Occupational Illnesses. The date of recordability for occupational illnesses is the date of initial diagnosis as an occupational illness, or, if the diagnosis follows a period during which a person has been unable to perform for unknown reasons, the date should be the first day of absence attributable to the illness which was later diagnosed or recognized.

4. Measurability of Recordable Injury and Illness Experience

4.1 General. Injury and illness experience can best be expressed as an incidence rate. Expressions of incidents per 200 000 employee-hours worked (approximately 100 employee-years) have been selected as given in 4.2 through 4.4.

4.2 Incidence Rate of Total Recordable Cases. This incidence rate is based upon the total number of recordable cases, as defined in 2.8, that occurred during the period covered by the rate. The following formula should be used:

Incidence rate of recordable cases

$$= \frac{\text{No. of recordable cases} \times 200\,000}{\text{Exposure or employee-hours}}$$

4.3 Incidence Rate of Deaths plus Lost Workday Cases with Days Away from Work. This incidence rate is based upon the total number of recordable cases which

¹ Only full days are counted. The day of the accident or onset of illness is not to be included.

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resulted in death plus the number of lost workday cases with days away from work, as defined in 2.10.1, that occurred during the period covered by the rate. The following formula should be used:

Incidence rate of deaths plus lost workday cases with time away from work

$$= \frac{\text{No. of recordable cases} \times 200\,000}{\text{Exposure or employee-hours}}$$

4.4 Incidence Rate of Lost Workdays. This incidence

rate is based upon the total number of workdays lost, as defined in 2.9.1, that occurred during the period covered by the rate. The following formula should be used: (See A4.4 of the Appendix.)

Incidence rate of lost workdays

$$= \frac{\text{No. of lost workdays} \times 200\,000}{\text{Exposure or employee-hours}}$$

NOTE: See A4.4 of the Appendix for an alternate measure of severity.

Appendix

(This Appendix is not a part of American National Standard for Uniform Recordkeeping for Occupational Injuries and Illnesses, Z16.4-1977, but is included for information purposes only.)

Guiding Interpretations and Examples

(The subdivisions of the Appendix are numbered to correspond with the section numbers in the standard. Since it is not necessary to have Appendix matter for every section in the standard, there are gaps in the numbering in the Appendix.)

A2. Definitions

A2.2 Exposure or Employee-Hours. Determination of employee-hours of exposure: Employee-hours of exposure for calculating incidence rates are to be actual hours worked. When actual hours are not available, estimated hours may be used. Employee-hours should be calculated as given under A2.2.1 and A2.2.2.

A2.2.1 Actual Exposure Hours. Employee-hours of exposure for nonexempt employees are to be taken from payroll or time-clock records and include only actual straight-time hours worked and actual overtime hours worked.

A2.2.2 Estimated Exposure Hours. When actual employee-hours of exposure are not available, estimated hours may be used. Such estimated hours should be obtained by multiplying the total employee-days worked for the period by the average number of hours worked per day. If the hours worked per day vary among departments, a separate estimate should be made for each department and these estimates added to obtain the total hours. Estimates of overtime hours should be included.

If employee-hours are estimated, indicate the basis on which estimates are made.

A2.2.2.1 Employees Living on Company Property. In calculating hours of exposure for employees who live on company property, only those hours during which employees were actually on duty are to be counted.

A2.2.2.2 Employees with Undefined Hours of Work. For traveling salesmen, executives, and others whose working hours are not defined, an average of 8 hours per day is to be assumed in computing exposure hours.

A2.2.2.3 Standby Employees. For standby employees, including seamen aboard vessels, who are restricted to the confines of the employer's premises, all standby hours must be counted.

A2.6 Medical Treatment. Medical treatment versus first aid: The important point to be stressed is that the decision as to whether a case involves medical treatment should be made on the basis of whether the case *normally* would require medical treatment. The decision cannot be made on the basis of who treats the case. First aid can be administered by a physician and medical treatment by someone other than a physician.

It is not possible to list all types of medical procedures and treatments and *on that basis alone* determine if first aid or medical treatment was involved. For example, whirlpool treatments, heat treatments, application of hot or cold compresses, or elastic bandages are not in and of themselves either first aid or medical treatment.

What follows is a discussion of diagnostic procedures and preventive procedures and treatments, both of which are not in and of themselves medical treatment. Next is a discussion of treatments that are almost always medical treatment, and comments on medical treatment and first aid for certain types of injuries.

A2.6.1 Diagnostic Procedures

A2.6.1.1 Hospitalization for observation, where no medical treatment is rendered other than first aid, is not considered medical treatment.

A2.6.1.2 Visits to a physician or nurse for observation *only* or for a routine change of dressing are not considered medical treatment.

A2.6.1.3 X-ray examination for fractures is considered diagnostic procedure and as such is not considered medical treatment or first aid. Where the x-ray is negative, the case is not recordable unless the injury required other medical treatment or met one of the other criteria for recordability.

A2.6.1.4 Physical examination yielding few or no findings and not substantiating subjective complaints in questionable cases is not considered medical treatment.

A2.6.1.5 Reactions to or effects of diagnostic procedures that are necessitated by a work-related injury or illness and which meet the criteria for recordability should be recorded.

A2.6.2 Preventive Procedures and Treatments

A2.6.2.1 Tetanus shots, either initial shots or boosters, are considered preventive in nature and are not in and of themselves considered medical treatment. However, treatment of a reaction to a tetanus shot administered because of an injury would be considered medical treatment and would make the case recordable.

A2.6.2.2 Any use of prescription medication normally constitutes medical treatment. However, it should be considered first aid when a single dose or application of a prescription medication is given on the first visit merely for relief of pain or as preventive treatment for a minor injury. This situation can occur at facilities having dispensaries stocked with prescription medications frequently used for preventive treatment and relief of pain and attended by a physician or registered professional personnel operating under the standing orders of a physician. The administration of nonprescription medication in similar circumstances would be considered first aid.

A2.6.2.3 The application of ointments and salves to prevent the drying or cracking of skin at the site of a minor injury can be considered first aid.

A2.6.2.4 The application of antiseptics to minor injuries which do not themselves require medical treatment can be considered first aid. Changing the bandage or dressing on an injury which did not require medical treatment, because the bandage or dressing has become dirty, is considered first aid.

A2.6.2.5 Reaction to preventive medication (not administered because of an occupational injury or illness) administered in-plant (such as flu shots) would not constitute a recordable case.

A2.6.2.6 In-plant treatment of off-the-job injuries and illnesses is not recordable.

A2.6.3 Treatments that Are Almost Always Medical Treatment. These treatments are as follows:

- (1) Suturing of any wound
- (2) Treatment of fractures
- (3) Application of a cast or other professional means of immobilizing an injured part of the body
- (4) Treatment of infection arising out of an injury
- (5) Treatment of a bruise by the drainage of blood
- (6) Surgical debridement, that is, the removal of dead or damaged tissue
- (7) Treatment of abrasions that occur to greater than full skin depth
- (8) Treatment of second- and third-degree burns

NOTE: Administration of prescription medicines is usually considered medical treatment (see A2.6.2.2).

A2.6.4 Medical Treatment and First Aid for Certain Types of Injuries

A2.6.4.1 Cuts and Lacerations

A2.6.4.1.1 First Aid. Treatment is limited to cleaning of the wound, soaking, application of antiseptic or nonprescription medication, and bandaging on the first visit. Followup visits are limited to observation, including changing of the dressing and bandage. Additional cleaning and application of antiseptic are permissible as first aid where required by work duties that are likely to soil the bandage. Application of butterfly closures for *cosmetic purposes only* can be considered first aid.

A2.6.4.1.2 Medical Treatment. The injury requires butterfly closures (for noncosmetic purposes), sutures (stitches), surgical debridement (cutting away dead tissue), treatment of infection, or other professional treatment.

A2.6.4.2 Abrasions

A2.6.4.2.1 First Aid. This is the same as for cuts and lacerations except that ointments can be added on followup visits to prevent drying and cracking of skin.

A2.6.4.2.2 Medical Treatment. The injury requires careful examination for removal of embedded foreign material, multiple soakings, whirlpool treatment, treatment of infection, or other professional treatment. This is any case involving more than a minor, spot-type injury. Treatment of abrasions occurring to greater than full skin depth is considered medical treatment.

A2.6.4.3 Bruises

A2.6.4.3.1 First Aid. Treatment is limited to a single soaking or application of cold compresses on a minor bruise. Followup visits are limited only to observation.

A2.6.4.3.2 Medical Treatment. The injury requires multiple soakings, draining of collected blood, or other extended care beyond observation.

A2.6.4.4 Splinters and Puncture Wounds

A2.6.4.4.1 First Aid. Treatment is limited to cleaning of the wound, removal of a foreign object(s) by tweezers or other simple techniques, application of antiseptics and nonprescription medications, and bandaging on the first visit. Followup visits are limited to observation, including changing of the bandage. Additional cleaning and application of antiseptic are permissible as first aid where required by work duties that are likely to soil the bandage.

A2.6.4.4.2 Medical Treatment. The injury requires removal of a foreign object(s) by a physician due to the depth of embedment, size or shape of the object(s), or location of the wound. This is also injuries requiring treatment for infection, treatment of a reac-

APPENDIX

tion to a tetanus booster, or other professional treatment.

A2.6.4.5 Burns, Thermal and Chemical (Resulting in Destruction of Tissue by Direct Contact)

A2.6.4.5.1 First Aid. Treatment is limited to cleaning or flushing of the surface; soaking; application of cold compresses, antiseptics, or nonprescription medications; and bandaging on the first visit. Followup visits are restricted to observation, changing of bandages, or additional cleaning. Most first-degree burns are amenable to first-aid treatment.

A2.6.4.5.2 Medical Treatment. The injury requires a series of treatments including soaks, use of whirlpools, and surgical debridement (cutting away dead tissue). Most second- and third-degree burns require medical treatment.

A2.6.4.6 Sprains and Strains

A2.6.4.6.1 First Aid. Treatment is limited to soaking, application of cold compresses, and use of an elastic bandage on the first visit. Followup visits are for observation, possibly including reapplying a bandage.

A2.6.4.6.2 Medical Treatment. The injury requires a series of hot and cold soaks, use of whirlpools, diathermy treatment, or other professional treatment.

A2.6.4.7 Eye Injuries

A2.6.4.7.1 First Aid. Treatment is limited to irrigation, removal of foreign material not embedded in the eye, and application of nonprescription medications. A precautionary visit (special examination) to a doctor is still considered first aid if treatment is limited to the aforementioned items. Followup visits are for observation only.

A2.6.4.7.2 Medical Treatment. This is cases involving removal of embedded foreign objects, use of prescription medications, or other professional treatment.

A2.6.4.8 Inhalation of Toxic or Corrosive Gases

A2.6.4.8.1 First Aid. Treatment is limited to removal of the employee to fresh air or the one-time administration of oxygen for several minutes.

A2.6.4.8.2 Medical Treatment. This is any professional treatment beyond the aforementioned. It includes all cases involving loss of consciousness.

A2.7 Work-Related Cases. The broad concept is that any injury or illness "occurring in and attributable to the work environment" is "work-related." Work environment is comprised of the physical location, equipment, materials processed or used, and the kinds of operations performed by an employee in the performance of his work, whether on or off the em-

ployer's premises. There are no stated exclusions of place or circumstance. Therefore, injuries or illnesses occurring in such places as the employee parking lot, lunchroom, or restroom, or during rest or lunch period on the employer's premises, can be work-related. The final determination of whether any case is work-related must be made by the employer. Responsibility or fault does not enter into the decision of whether a case is work-related. In doubtful situations, a case should be recorded.

A2.8 Recordable Cases. Recordable work-related cases are those that involve any of the following:

(1) Deaths, regardless of the time between occupational injury or illness and death

(2) All occupational illnesses, including, but not limited to, the following categories and examples:

(a) Occupational skin diseases or disorders

Examples: contact dermatitis, eczema, or rash caused by primary irritants and sensitizers, or poisonous plants; oil acne; chrome ulcers; chemical burns or inflammations. (Direct contact causing tissue damage only, resulting from a thermal or chemical burn, is classified as an injury, not an illness case.)

(b) Dust diseases of the lungs (pneumoconioses)

Examples: silicosis, asbestosis, coal worker's pneumoconiosis, byssinosis, and other pneumoconioses.

(c) Respiratory conditions due to toxic agents

Examples: pneumonitis; pharyngitis; rhinitis or acute congestion due to chemicals, dusts, gases, or fumes; farmer's lung.

(d) Poisoning (systemic effects of toxic materials)

Examples: poisoning by lead, mercury, cadmium, arsenic, or other metals; poisoning by carbon monoxide, hydrogen sulfide, or other gases; poisoning by benzol, carbon tetrachloride, or other organic solvents; poisoning by insecticide sprays such as parathion, lead arsenate; poisoning by other chemicals such as formaldehyde, plastics, and resins.

(e) Disorders due to physical agents (other than toxic materials)

Examples: heatstroke, sunstroke, heat exhaustion, and other effects of environmental heat; freezing; frostbite and effects of exposure to low temperatures; caisson disease; effects of ionizing radiation (isotopes, x-rays, radium); effects of nonionizing radiation (welding flash, ultraviolet rays, microwaves, sunburn).

(f) Disorders associated with repeated trauma

Examples: noise-induced hearing loss; synovitis, tenosynovitis, and bursitis; raynaud's phenomenon; and other conditions due to repeated motion, vibration, or pressure.

(g) All other occupational illnesses

Examples: anthrax, brucellosis, infectious hepatitis, malignant and benign tumors, food poisoning, histoplasmosis, coccidioidomycosis.

(3) Injuries resulting in any of the following:

- (a) Lost workdays — either days away from work or days of restricted work activity
- (b) Medical treatment other than first aid
- (c) Loss of consciousness
- (d) Restriction of work or motion
- (e) Temporary or permanent transfer
- (f) Termination of injured or ill employee

Loss of consciousness of the employee for any period of time is self-explanatory. Restriction of motion is not defined specifically. Each case must be judged individually to determine if there is more than a trivial amount of restricted motion, such as would occur when a small adhesive bandage was placed on the second joint of the finger. It should be noted here that damage to prostheses (such as false teeth) is not in and of itself grounds for recordability unless accompanied by other damage to the body that meets the recordability criteria.

A2.10.1 Lost Workday Cases with Days Away from Work. These are cases that result in 1 or more days away from work. Days away from work are those workdays (consecutive or not) on which the employee would have worked but could not because of occupational injury or illness. The number of lost workdays should not include the day of injury or onset of illness or any days on which the employee would not have worked even though able to work.

For example, if an employee who is scheduled to work Monday through Friday has a recordable case on Friday and returns to work on Monday, the case does not involve any days away from work even if the employee was unable to work on Friday, Saturday, or Sunday. If this same employee had been scheduled to work on Saturday, even if that Saturday constituted overtime, the Saturday would be counted as days away from work, and the case would be classified as a lost workday case with days away from work.

For employees not having a regularly scheduled shift, for example, certain truck drivers, construction workers, farm labor, casual labor, part-time employees, etc, it may be necessary to estimate the number of lost workdays. Estimates of the number of days that the employee would have worked should take into account the prior work history of the employee and days worked by employees, not ill or injured, working in the same department or occupation as the ill or injured employee.

In some cases an injured or ill employee will miss one or more scheduled days or shifts besides the day of injury or onset of illness, but it will be uncertain

whether the employee was truly unable to work on the days missed. Such cases may arise when a doctor judges that the employee is able to work but the employee decides that he is not. In such cases, the employer should not rely solely on the doctor's opinion. He should make the final judgment himself based on all the evidence at his disposal. Again, the rule should be "when in doubt, record the case."

A2.10.2 Lost Workday Cases with Days of Restricted Work Activity Only. These are cases that result in 1 or more days of restricted work activity but do not result in any days away from work.

Days of restricted work activity include those days (consecutive or not, but excluding the day of injury or onset of illness) on which one of the circumstances described in A2.10.2.1 through A2.10.2.3 occurred.

A2.10.2.1 Temporary Assignment. The employee was assigned to another job on a temporary basis. Even if the employee normally shifts from job to job within an occupational classification, if any switch or transfer is occasioned by a work-related injury or illness, the case involves days of restricted work activity. Such days are meant to cover all days on which the employee was unable to contribute a full day's work on all parts of his permanent job. In cases where an employee is not working at his regular job and is injured or becomes ill and is transferred back to his original job, which he can perform without limitation, there are no days of restricted work activity.

A2.10.2.2 Loss of Part of Shift. The employee worked at a permanent job less than his full shift or normal day. Loss of a full day or shift would constitute a lost workday away from work.

A2.10.2.3 Restricted Work Activity. The employee worked at a permanently assigned job but could not perform all duties normally connected with it. All days (excluding the day of injury or onset of illness) for which the employee was scheduled to work and could not perform all or any part of his normal assignment during all or any part of the workday or shift should be considered days of restricted activity.

A4. Measurability of Recordable Injury and Illness Experience

A4.4 Incidence Rate of Lost Workdays (Alternate Method)

A4.4.1 Each death resulting from occupational injury or illness is assigned a time charge of 6000 days.

A4.4.2 Each permanent total disability resulting from an occupational injury or illness is assigned a time charge of 6000 days. (A permanent total disability is

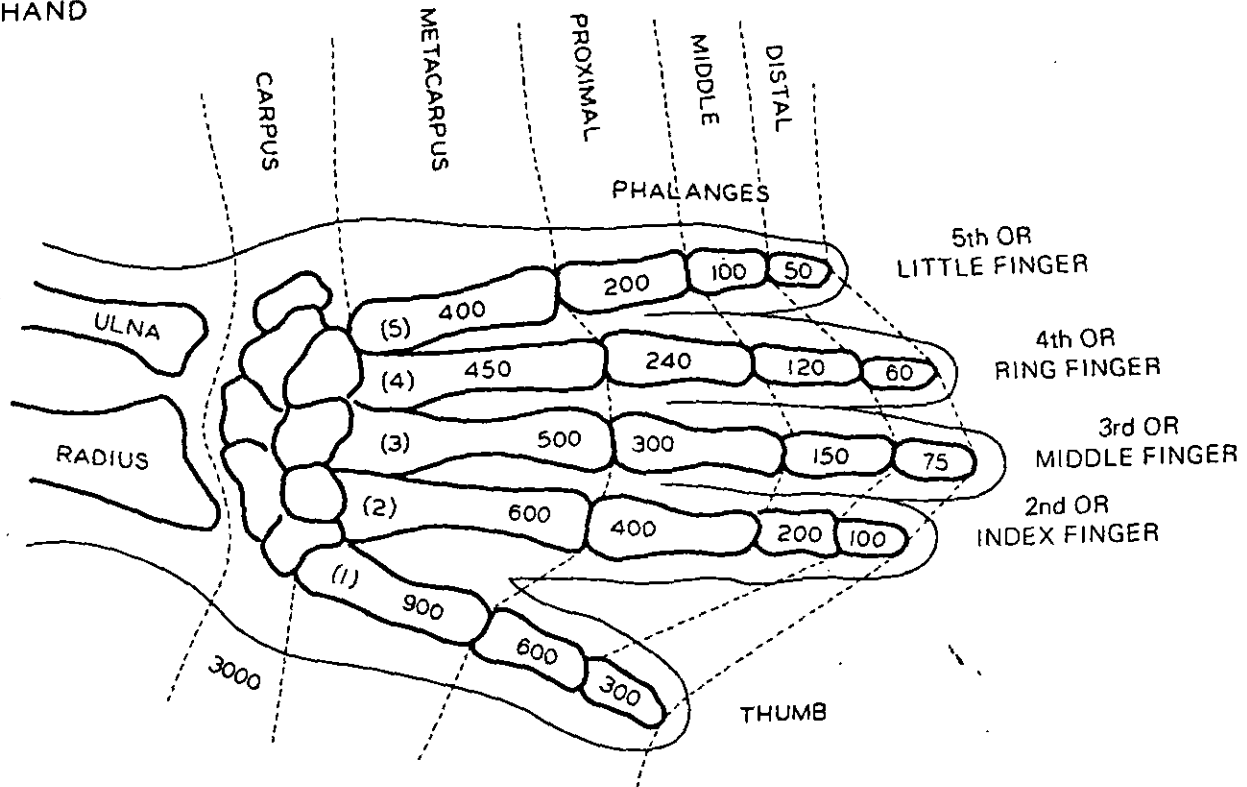
APPENDIX

Table A1
Tabulation of Scheduled Charges
A. For Loss of Member – Traumatic or Surgical

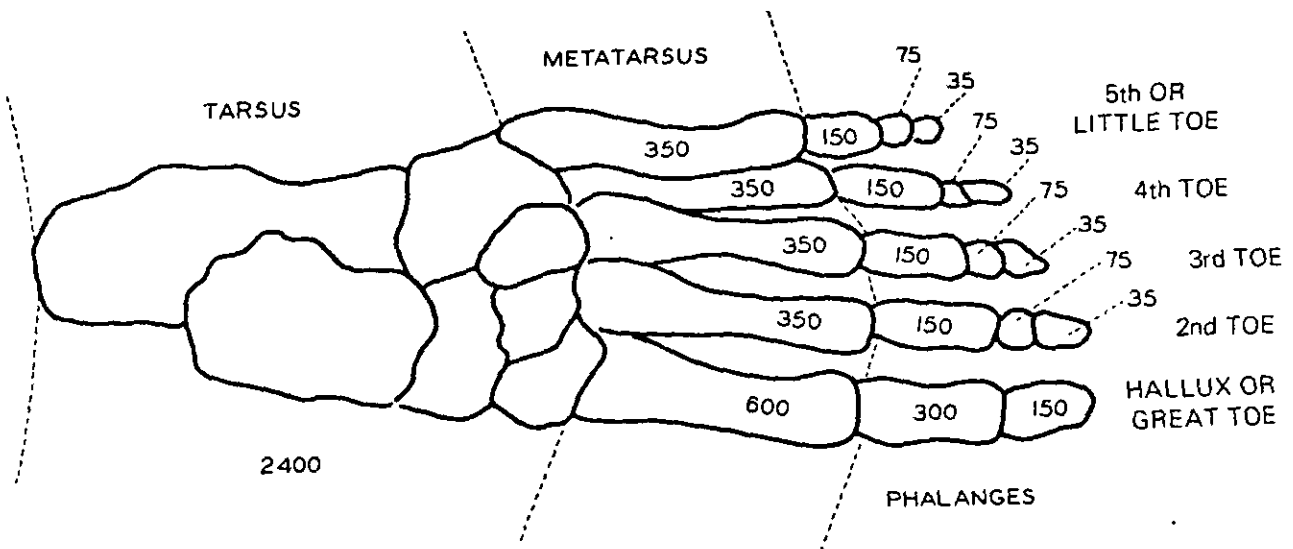
Fingers, Thumb, and Hand (see Fig. A1)						
Amputation Involving All or Part of Bone*	Hand	Thumb	Fingers			
			Index	Middle	Ring	Little
Distal phalange	—	300	100	75	60	50
Middle phalange	—	—	200	150	120	100
Proximal phalange	—	600	400	300	240	200
Metacarpal	—	900	600	500	450	400
Hand at wrist	3000	—	—	—	—	—
Toe, Foot, and Ankle (see Fig. A1)						
Amputation Involving All or Part of Bone*	Foot		Great Toe	Each of Other Toes		
Distal phalange	—		150	35		
Middle phalange	—		—	75		
Proximal phalange	—		300	150		
Metatarsal	—		600	350		
Foot at ankle	2400		—	—		
Arm						
Any point above elbow, including shoulder joint						4500
Any point above wrist and at or below elbow						3600
Leg						
Any point above knee						4500
Any point above ankle and at or below knee						3000
B. Impairment of Function						
One eye (loss of sight), whether or not there is sight in the other eye						1800
Both eyes (loss of sight) in one accident						6000
One ear (complete industrial loss of hearing), whether or not there is hearing in the other ear						600
Both ears (complete industrial loss of hearing) in one accident						3000
Unrepaired hernia						50

*If the bone is not involved, use actual days lost. The tuft of the distal bone of a finger or toe is considered bone if it shows in x-rays.

HAND



FOOT



NOTES:

- (1) Numbers on the bones are the charges for loss involving part or all of the bone.
- (2) The tuft of the distal bone in a finger or toe is considered bone if it shows in x-rays.

Fig. A1
Chart of Scheduled Charges for Hand and Foot

APPENDIX

any injury or illness other than death that permanently and totally incapacitates an employee from following any gainful occupation, or which results in the loss or the complete loss of use of any of the following in one accident: both eyes; one eye and one hand, arm, leg, or foot; any two of the following not on the same limb: hand, arm, foot, or leg.)

A4.4.3 Each case of permanent loss or loss of use of a part of the body resulting from an occupational injury or illness is assigned a time charge in days in accordance with schedules given in Table A1 and Fig. A1. Disregard any actual lost workdays; use scheduled days only. The days charged due to permanent impairment of function are that percentage of the scheduled charge

corresponding to the percentage of loss of function determined by the physician treating the case.

A4.4.4 To determine the incidence rate of lost workdays, add the days lost in lost workday cases with days away from work and any scheduled days charged as determined in A4.4.1 through A4.4.3 for deaths, cases of permanent total disability, or loss of parts of the body or their function, and enter the total days in the following formula:

Incidence rate of lost workdays

$$= \frac{\text{Total lost workdays or days charged as described in A4.4.4} \times 200\,000}{\text{Exposure or employee-hours}}$$

American National Standards

The standard in this booklet is one of nearly 8500 standards approved to date by the American National Standards Institute.

The Standards Institute provides the machinery for creating voluntary standards. It serves to eliminate duplication of standards activities and to weld conflicting standards into single, nationally accepted standards under the designation "American National Standards."

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