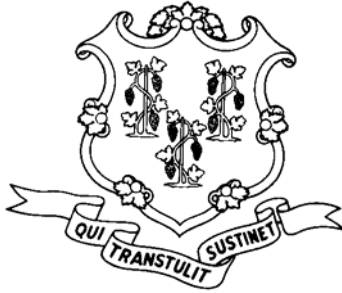


Occupational Disease in Connecticut, 2007



This report covers data for 2005
and was prepared under contract for the
State of Connecticut Workers' Compensation Commission
John A. Mastropietro, Chairman
as part of the Occupational Disease Surveillance Program operated
in cooperation with the Connecticut Department of Labor and the
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A. Executive Summary

This report focuses on occupational *disease* reports from 2005, and recent trends in reported cases. It does not address traumatic occupational *injuries*, which are addressed in the annual report on occupational injuries and illnesses by the Connecticut Department of Labor. Occupational diseases are typically harder to detect than injuries, since they often occur over longer periods of time, and can have multiple (including non-occupational) risks. Therefore, this report uses data from three primary sources as a way of establishing a more complete picture of occupational disease: Workers' Compensation First Report of Injury cases, Physicians' Reports under the Occupational Disease Surveillance System (ODSS), and the Bureau of Labor Statistics/Conn-OSHA Annual Survey. Occupational disease can have major impacts on worker health, ability to work, and employer costs. Some diseases, such as cancers from asbestos exposure or HIV or hepatitis from exposure to bloodborne agents in health care, can be fatal. Other diseases, such as Carpal Tunnel Syndrome from ergonomic problems, can result in high levels of disability from loss of use of the hands. Prevention efforts, such as effective health and safety committees, ergonomic programs, or use of safe needle devices can reduce both disease and costs; in theory, all occupational diseases are preventable.

Table A-1: Summary of Diseases Reported by Systems, 2004-5

Type of Disease	BLS/Conn-OSHA		Workers' Comp.		ODSS (Physicians)	
	2004	2005	2004	2005	2004	2005
Lung & Poisoning	389	488	335	359	173	191
Lead					342	463
Skin	832	848	222	208	194	241
MSD	*	*	2,114	1485	488	511
Other	3,352	3515	1,196	956	69	100
Total	4,572	4,851	3,867	3,008	1,266	1,506

Sources: BLS: Bureau of Labor Statistics/Conn-OSHA; Total differs due to rounding for the survey

WCC: CT Workers' Compensation Commission, First Report of Injury database

ODSS: Occupational Disease Surveillance System, Connecticut Departments of Public Health and Labor

Notes: MSD= Musculoskeletal Disorders; Definitions vary somewhat between systems; ODSS infectious does not include bloodborne; ODSS lead cases are from the lab reporting system.

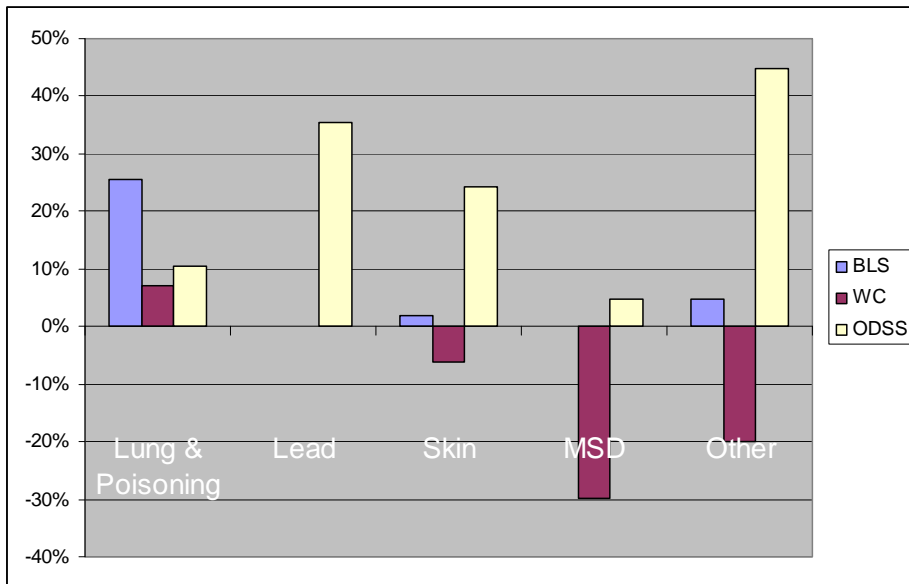
*MSD is included in "other"

Table A-1 and Figure A-1 summarize the data from the three different sources for 2004 and 2005. Approximately 4,900 cases of occupational diseases were reported under the BLS/Conn-OSHA survey, with 3,000 reported by employers under Workers' Compensation, and 1,500 reported by physicians to the ODSS. Reports from the BLS system increased overall across the two years, decreased in workers' compensation, and increased based on physician reports. The number of cases decreased in all but one category in Workers' Compensation from 2004 to 2005.

All systems were dominated by reports of **musculoskeletal disorders** (MSDs) such as Carpal Tunnel Syndrome and tendonitis, which accounted for between 34-49% of cases reported (MSD was not broken out by BLS starting in 2002, and is partially included under "other illness"). **Lung diseases** such as acute respiratory conditions and asthma accounted for 10-13% of cases. "Other diseases", which includes **infectious diseases**, physical hazards such as heat and cold, allergies, cancer, and others, accounted for 5-65% of cases (the number in workers' compensation is due primarily to infectious, and MSD for BLS). **Skin conditions** accounted for 7-17% of the conditions reported. **Lead**

poisoning is tracked based on laboratory reports to the Connecticut Department of Public Health, and accounted for 31% of ODSS cases.

Figure A-1: Increase/Decrease in Reports by Type of Condition and System, 2004-2005



There was an overall illness rate of 30.0 per 10,000 workers based on the BLS survey and 18.6 based on workers’ compensation. Local government had the highest rate (67.1 cases per 10,000 full time employees), followed by Manufacturing (62.9), Education and health services (61.8), and State Government (57.4) based on BLS data. The highest sectors based on workers’ compensation data were Education and Health (dominated by local government employees) at 26.9 per 10,000 workers, followed closely by Manufacturing (26.1) and General Government (primarily local government) at 24.3.

Overall, 47% of reports were by women, but with higher proportions for MSD and infectious, but lower levels for skin, “other”, and lung (WC). Based on physician reports, 8% of cases were from Hispanics, and 14% were from Blacks, with 33% of cases for those 40-49 years old.

The most common MSDs diagnosed by physicians were Carpal Tunnel Syndrome, epicondylitis, and tendonitis (ODSS). The most common causes of MSD were “repetition”, lifting, computers, tool use, machines, and pushing and pulling (WC). The most common lung diseases were respiratory conditions, asthma/RADS, rhinitis/sinusitis, bronchitis, and hypersensitivity pneumonitis (ODSS). Chemicals (including cleaning chemicals), mold, fumes, gases and carbon monoxide, and indoor air quality were the most common causes (ODSS). Causes of skin conditions included poison ivy, chemicals, and cleaning products (ODSS). The most common infectious diseases were bloodborne diseases and exposures, Lyme Disease or tick bites, and TB exposures/conversions

B. Introduction

This report provides an overview of what is known about occupational disease in Connecticut based on 2005 data. It is one of a series of annual reports on occupational disease developed for the Connecticut Workers' Compensation Commission under the Occupational Disease Surveillance System. By monitoring trends, this system helps prevent occupational disease by targeting prevention activities such as education, encouraging effective safety and health committees and programs, and investigating of clusters of disease. The system is a cooperative venture by the Department of Public Health, Department of Labor, Workers' Compensation Commission, and a number of occupational health clinics (Connecticut General Statutes 31-396 to 31-402). Physicians are required to report occupational disease under Connecticut General Statute 31-399.

This report combines available data from a number of systems:

- Bureau of Labor Statistics/Connecticut Occupational Safety and Health Administration (BLS/Conn-OSHA) Survey of Occupational Injuries and Illnesses
- Connecticut Adult Blood Lead Epidemiology Surveillance System (ABLES)
- Connecticut Occupational Disease Surveillance System (referred to as Physicians' Reports or ODSS in this report)
- Connecticut Workers' Compensation Employer First Reports of Injury (referred to as Workers' Compensation or WCC in this report)

Acknowledgements

Several people have contributed data and other help to this report. We would like to thank especially Joe Weber of the Department of Labor; Bob Artus, and Peter Miecznikowski of the Workers' Compensation Commission; and Thomas St. Louis of the Department of Public Health. Colleagues at the Division of Occupational and Environmental Medicine at the University of Connecticut Health Center have contributed ideas and resolved questions.

Overview of Report

This report covers occupational disease data for calendar year 2005. It is divided into three primary sections based on the data source. It begins with the BLS/Conn-OSHA time trends, followed by data from the Workers' Compensation First Reports of Injury, followed by data from the Physicians' Reports.

All three data sources provide somewhat different information. For example, the BLS/Conn-OSHA provides comparisons to U.S. data, but is based on a survey, rather than all reports. Workers' Compensation data includes all lost-time cases for all employers, but does not include physicians' diagnosis. The Physicians' reporting system has more precise diagnoses, but according to the Department of Public Health, a large number of physicians do not report into the system. Prior studies of cumulative trauma reports in Connecticut have found that there is only a small overlap between the Workers' Compensation Reports and the Physicians' Reports.

C. Bureau of Labor Statistics/Connecticut Occupational Safety and Health Administration Surveys

In cooperation with the U.S. Bureau of Labor Statistics (BLS), Conn-OSHA conducts an annual survey of employers for job-related injuries and illnesses. Conn-OSHA issues an annual report that provides data on injuries (available at <http://www.ctdol.state.ct.us/osha/shstats.htm>). This report focuses on illnesses, and includes data from Conn-OSHA that is not published in that report. The Connecticut Department of Labor acknowledges that the BLS/Conn-OSHA survey under-counts occupational diseases, particularly chronic diseases, since these are frequently not recognized or reported.

Occupational Illnesses in 2005

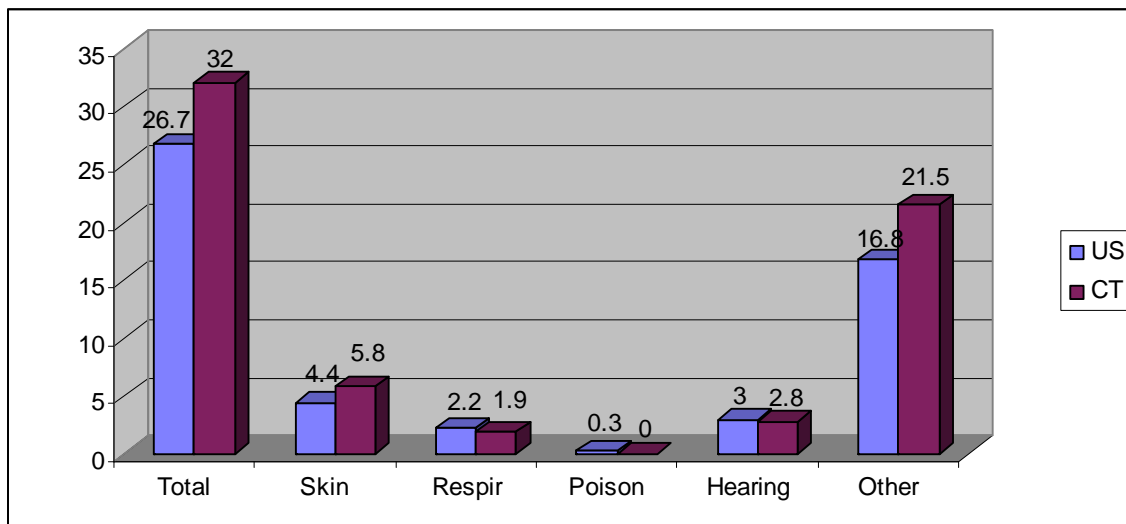
There were 4,851 reported cases of occupational illnesses in 2005 (Figure C-1 and Table C-1), a 6% increase from 2004 for the number of cases. Cases of hearing loss decreased by 18%, but this was offset by an increase of 36% in respiratory cases and 9% in the much larger category of “other illnesses”, which is dominated by repetitive trauma cases. The number of poisonings declined by 77%, but is a very small number of cases.

Table C-1: Occupational Disease by Type, 2004 and 2005, BLS/Conn-OSHA

	2004		2005		% Change in Cases
	Cases	Rates	Cases	Rates	
Skin	832	5.2	848	5.3	2%
Poisonings	35	0.2	8	0.0	-77%
Respiratory	354	2.2	480	3.0	36%
Hearing loss	466	2.9	381	2.4	-18%
Other Illnesses	2,886	18.0	3134	19.4	9%
Total	4,573	28.5	4,851	30.0	6%

Source: BLS/Conn-OSHA; Rates are per 10,000 workers, not adjusted for hours worked. Total differs due to rounding for the survey. Includes public sector.

Figure C-1: Rates of Occupational Illness by Type, Private Sector, US and CT, 2005



Source: BLS and Conn-OSHA. Rates per 10,000 workers, adjusted for hours worked.

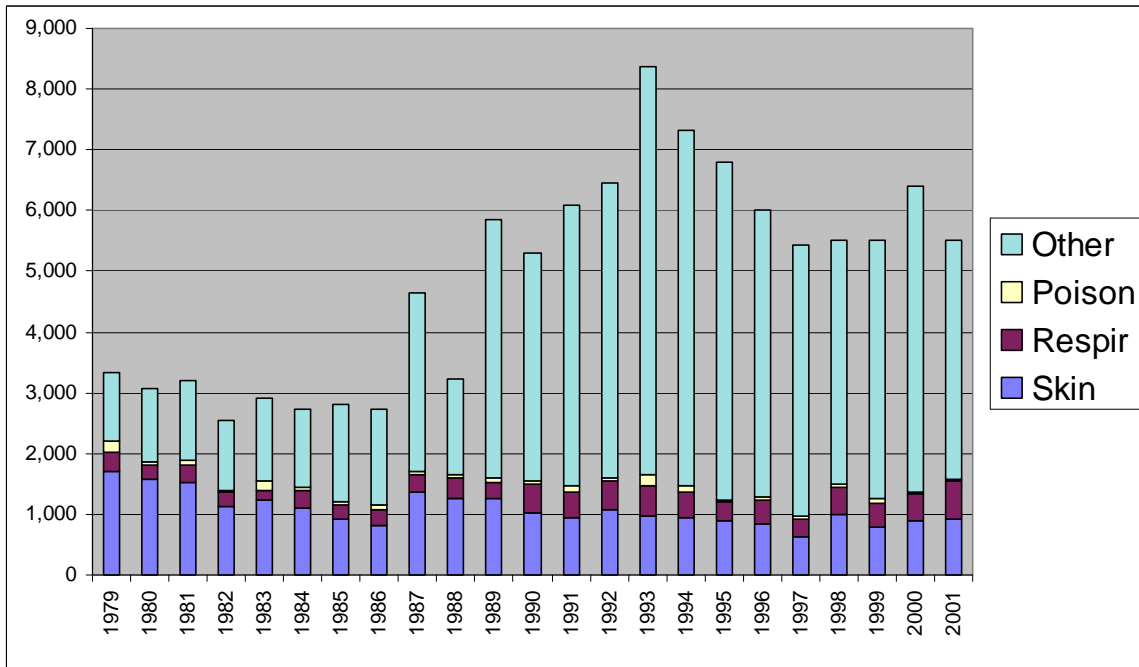
Overall rates for the private sector in Connecticut for 2005 are compared to the U.S. rates in Figure C-1 (public sector rates are not available on the national level for comparison). The overall Connecticut rate (32.0) was higher than U.S. rate (26.7). This was driven by higher CT rates for the large categories of skin disease and “other” which includes repetitive trauma). There were slightly lower rates in CT for the smaller categories of respiratory conditions, poisonings, and hearing loss. Rates are adjusted for hours worked, and are for the private sector only since government sector statistics are not available for the U.S.

Reported cases of illness peaked at 8,369 for Connecticut in 1993, and then in general declined to 5,514 in 2001 (Figure C-2). After the recordkeeping change in 2002 (see below), numbers have gradually increased from 4,387 to 4,850 in 2005 (Figure C-3).

Recordkeeping Changes in 2002

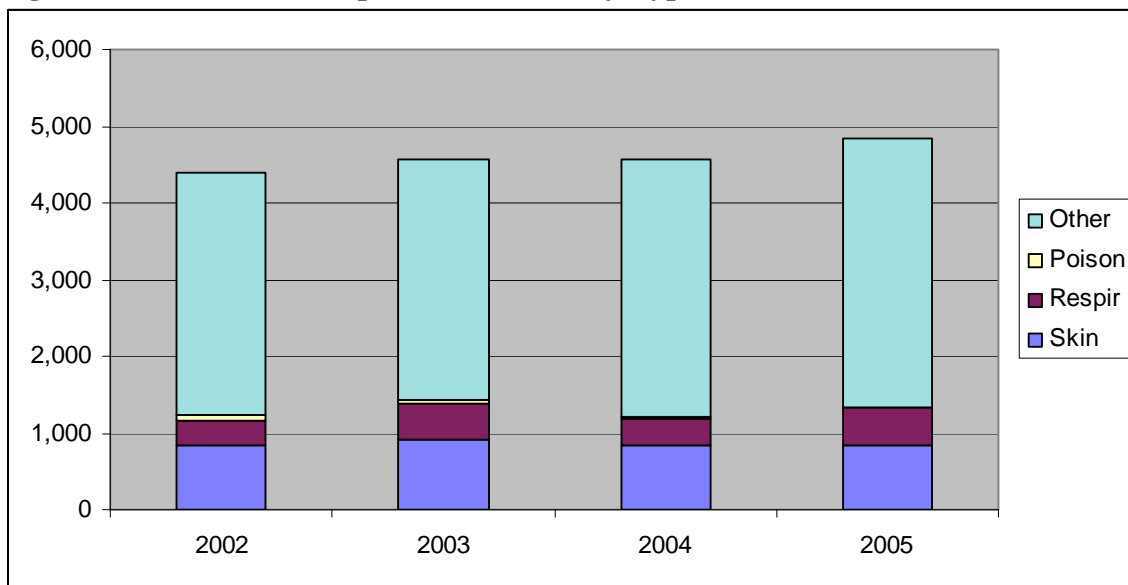
The BLS survey had a number of changes in 2002 that make it more difficult to compare with previous years, and the BLS has advised that the statistics for 2002 (and following years) are not comparable to prior years as a result of those changes. As part of that new recordkeeping rule, several categories of occupational illness were no longer tracked, including the previously most common category of “repetitive trauma”, as well as “dust diseases of the lung” and “disorders due to physical agents”. In addition, the definition of what must be recorded for illnesses has changed to be the same as for injuries; previous to 2002, all illnesses needed to be recorded, regardless of lost time status. The newer definitions require recording for only conditions that result in lost time or medical attention beyond first aid. In addition, now only previously-existing conditions that are “significantly” aggravated by work need to be recorded (prior to 2002, the definition did not include “significantly”). The new guidance reinforces the requirement that all fatal heart attacks that occur on the job need to be reported (not only work-related cases if it is later determined that it was solely due to events or exposures outside of work, then it not recordable). There were numerous other changes as well, including hearing loss, needlesticks, TB conversion, and other issues that are likely to affect the data. In general, it is likely that the “occupational illness” category as a whole is substantially smaller than previously due to these changes, but the extent cannot be known. Long-term trend data is therefore broken out into two sets of figures, one for 1991 through 2001, and the other for 2002 - present.

Figure C-2: Cases of Occupational Disease by Type and Year, CT, 1979-2001



Source: BLS/Conn-OSHA Survey

Figure C-3: Cases of Occupational Disease by Type and Year, CT, 2002-2005



Source: BLS/Conn-OSHA Survey

BLS has advised that 2002 figures are not comparable to prior years due to changes in recordkeeping requirements.

Numbers and rates by industry sector are presented in Table C-2, based on the NAICS (North American Industrial Classification System), which replaced the previously used SIC (Standard Industrial Classification) system in 2003.

Table C-2: Illness Rates per 10,000 Workers by Industry and Type of Illness, CT, 2005

	Total		Skin		Respiratory		Poison		Hearing		Other	
	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.
Total, all industries	36.0	4.9	6.3	0.8	3.6	0.5	-7	**	2.8	0.4	23.3	3.1
Private Industry only	32.0	3.8	5.8	0.7	1.9	0.2	**	**	2.8	0.3	21.5	2.5
<i>Goods Producing</i>	53.2	1.4	9.6	0.3	1.6	*	**	**	12	0.3	30	0.8
Natural resources and mining	49.1	*	40.1	*	--	--	**	**	**	**	**	**
Construction	22.3	0.1	--	--	--	--	**	**	**	**	17.4	0.1
Manufacturing	62.9	1.2	10.4	0.2	1.8	*	**	**	16	0.3	34.7	0.7
<i>Service Providing</i>	25.9	2.4	4.7	0.4	2	0.2	**	**	0.2	*	19	1.7
Trade, transport, utilities	15.6	0.4	3.3	0.1	0.9	*	**	**	**	**	11.1	0.3
Information	26.8	0.1	4.7	*	**	**	**	**	**	**	21	0.1
Financial activities	19.3	0.2	3.8	*	--	--	**	**	**	**	12.9	0.2
Professional/business services	14.2	0.2	--	--	**	**	**	**	**	**	9.4	0.2
Education and health	61.8	1.2	6.5	0.1	4.4	0.1	**	**	**	**	50.8	1
Leisure and hospitality	11.3	0.1	4	*	4	*	**	**	**	**	3.1	*
Other services	17.7	0.1	--	--	--	--	**	**	**	**	5.5	*
<i>Government total</i>	64.3	1.1	10	0.2	15.4	0.3	**	**	2.7	*	36.1	0.6
State Government	57.4	0.3	5.5	*	21.5	0.1	**	**	--	--	29.4	0.1
Local Government	67.1	0.8	11.8	0.1	12.9	0.2	**	**	3.3	*	38.8	0.5

Source: Conn-OSHA

Rates are adjusted for hours worked, and are per 10,000 full-time workers; Cases are in 1,000's.

*less than 50 cases

**less than 15 cases

Overall, the adjusted rate is 36.0 cases of occupational illness per 10,000 CT workers, a 3% increase from the 2004 rate of 34.9. The overall private sector rate was 32.0, with a government rate that is slightly more than twice as high, at 64.3.

Of specific industries, Manufacturing and Education/health services had the highest number of cases of illness, (both with approximately 1,200 cases), followed by local government with 800. However, local government had the highest rate (67.1 cases per 10,000 full time employees), followed by Manufacturing (62.9), Education and health services (61.8), and State Government (57.4).

Local Government was dominated by “Other” illnesses (459 cases), followed by Respiratory conditions with 152 cases and skin conditions with 139 cases. The highest categories for State Government were respiratory (102) and “Other” (139) illnesses. Manufacturing was dominated by “Other” illnesses (684), with 316 hearing loss cases and 204 skin conditions reported.

Repetitive trauma cases have historically been the highest contributor to occupational illness rates, but this category of illness stopped being collected in 2002. Some of these cases appear as “other illnesses”, but the BLS instructions are not clear on whether they need to be recorded there or not since they do not give specific examples of these conditions (such as Carpal Tunnel Syndrome or tendonitis)

in their instructions, although chronic conditions are supposed to be recorded as illnesses. It is likely that these cases are under-recorded in comparison to previous years. Some information is available on lost-time conditions (see below).

Reported rates were the highest for larger workplaces in 2005, with 10.8 cases per 10,000 workers for 10 or fewer employees, 15.4 for 11-49 employees, 38.8 for 50-249 employees, 65.8 with 250-999 employees, and 53.1 for 1,000 employees and over (Table C-3). Compared to 2004, reported cases decreased greatly for employers in the 11-49 size category (after a large increase in 2003) and increased for all others except the largest, which stayed fairly constant. However, studies in Connecticut have shown that the smallest employers tend to under-report, so some of these differences may be due to variable reporting.

Table C-3: Rates by size of employer, BLS/ConnOSHA, 2005

	Cases	Rate	Change from 2004
1-10 employees	193	10.8	107
11-49 employees	501	15.4	-716
50-249 employees	1,639	38.8	382
250-999 employees	1,444	65.8	536
1,000+ employees	1,074	53.1	-29
Total	4,850	36.0	278

Lost-Time Illnesses

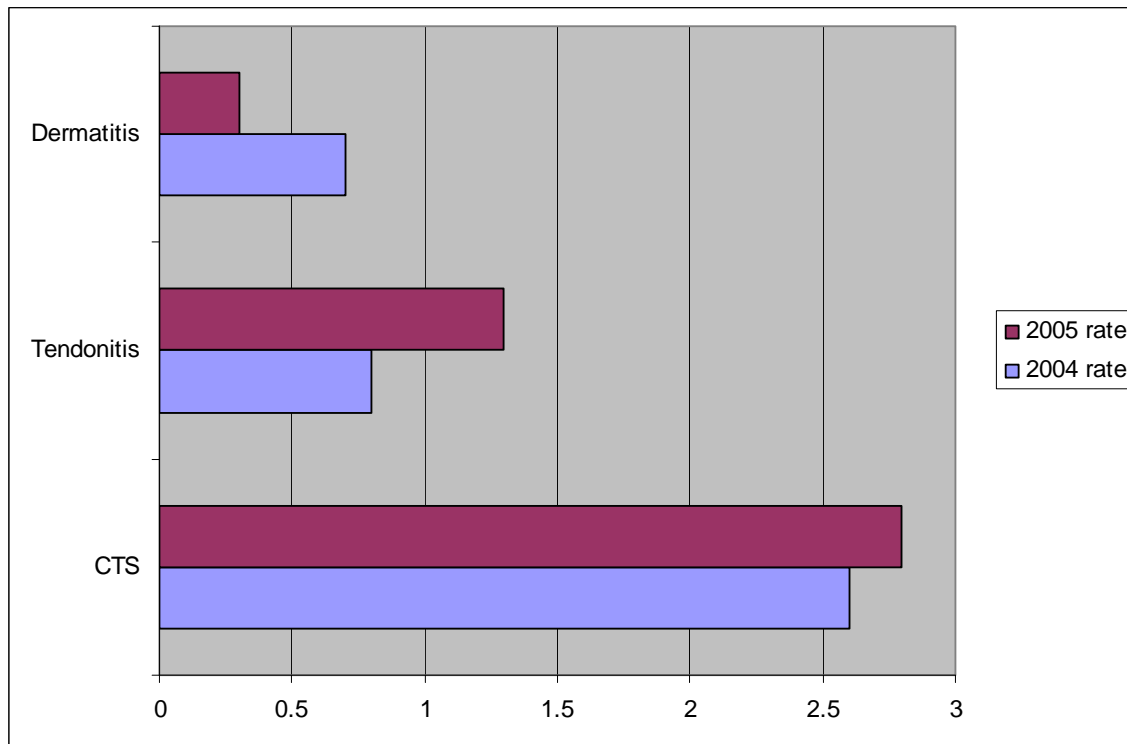
BLS obtains additional data for the subset of cases that result in lost worktime (restricted work cases are not included in this section, which is about half again the number of lost worktime cases), that provide additional detail on specific conditions and causes. We are presenting here this data for 2004 and 2005 for conditions that are more chronic in nature (usually classified as occupational illness).

Musculoskeletal Conditions

Musculoskeletal conditions are the most common category of specific injury and illness conditions, and is a category that includes both chronic conditions and sprains and strains from overexertion (approximately 75% of these cases nationally). BLS defines this fairly complex category as “Includes cases where the nature of injury is: sprains, strains, tears; back pain, hurt back; soreness, pain, hurt, except back; carpal tunnel syndrome; hernia; or musculoskeletal system and connective tissue diseases and disorders and when the event or exposure leading to the injury or illness is: bodily reaction/bending, climbing, crawling, reaching, twisting; overexertion; or repetition. Cases of Raynaud’s phenomenon, tarsal tunnel syndrome, and herniated spinal discs are not included.”

Private sector musculoskeletal conditions decreased from 6,420 in 2004 to 6,250 in 2005 (the rate per 10,000 workers decreased from 56.1 to 52.9). The Connecticut rate is 28% higher than the national MSD rate of 41.3. MSD accounted for 32.5% of the total of 19,180 private-sector lost time injuries and illnesses in Connecticut. There were an additional 1,140 cases in the public sector, for a total of 7,390 cases for Connecticut.

Figure C-4: Rates of Conditions, Lost-time Only, Private Sector, CT, 2004 and 2005



Source: BLS Website <http://www.bls.gov/iif/home.htm>

Rates are cases per 10,000 full time employees

CTS=Carpal Tunnel Syndrome:

Carpal Tunnel Syndrome (CTS) was the most common specific illness, with a rate rising from 2.6 per 10,000 workers to 2.8 (Figure C-4) and approximately 4,200 lost-time cases (plus 800 in the public sector). CTS also had the second highest median lost work days of any condition (fractures was highest at 33 days), with a median of 31 days of lost time per case (compared to 7 days for all cases of injury and illness), with 52.9% of lost time cases with 31 or more days lost. Tendonitis increased from 0.8 cases per 10,000 to 1.3, and a median of 15 days of lost time per case.

The 10,100 cases caused by “Repetitive Motion” had a median of 29 days away from work.

Dermatitis

Lost-time dermatitis cases decreased slightly from 0.7 to 0.3 cases per 10,000.

D. Workers' Compensation First Report of Injury Data

There were a total of 3,008 Workers' Compensation reports for occupational illness in 2005, a 22% decrease from 2004. Occupational illness cases are a subset of illnesses combined with traumatic injuries, representing 10.2% of the 29,503 total reports filed in 2005 (there were 36,003 in 2004).

Table D-1 and Figure D-1 show the total reports for the previous ten years, indicating a steady increase in reports between 1996-1999, with a leveling in 2000, overall decrease to 2003, then a 34% increase in 2004 and decrease in 2005. Since there were some database problems in 2003, it appears that reports have been relatively flat (typically in the low 3,000's) since 2001.

There were decreases in almost all categories of illness in 2005 based on these reports, including decreases of 30% in musculoskeletal disorders (MSD), 27% in heart/stress conditions, and 24% for infectious conditions. Employment rates were fairly stable in 2004, so the overall illness rate also decreased by about the same amount as the overall number of cases (23%).

Table D-1: Occupational Disease by Type, WCC, 1996-2005

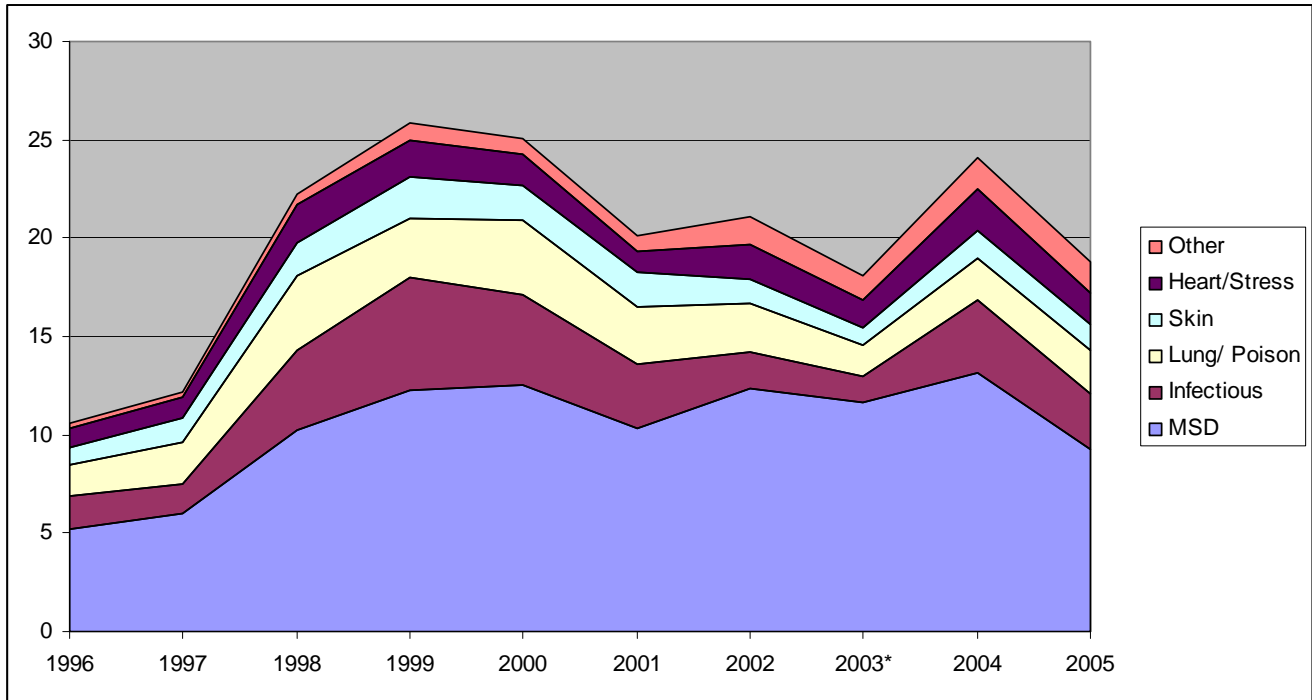
	1996	1997	1998	1999	2000	2001	2002	2003*	2004	2005
MSD	807	936	1,634	1,998	2,075	1,619	1,978	1,858	2,114	1,485
Infectious	249	242	653	930	748	516	291	218	590	450
Lung/ Poison	249	329	603	497	630	463	409	246	335	359
Skin	136	202	270	343	291	268	196	147	222	208
Heart/Stress	145	161	301	298	274	171	280	220	344	251
Other	45	48	95	148	129	119	226	202	262	255
Total Illnesses	1,631	1,918	3,556	4,214	4,147	3,156	3,380	2,891	3,867	3,008
Employment	1538000	1570500	1596900	1630000	1653000	1571664	1602000	1598200	1603100	1614100
Rate per 10,000	10.6	12.2	22.3	25.9	25.1	20.1	21.1	18.1	24.1	18.6

Note: Employment figures are not adjusted for hours worked

* This may be an incomplete database (2003)

Illness reports were dominated by musculoskeletal disorders with 1,485 cases in 2005 (49% of the total occupational illnesses). There were 450 cases of infectious diseases (15%), 359 (12%) cases of lung diseases, (which includes acute respiratory diseases, chronic lung diseases, and poisonings), 208 cases of skin conditions (7%), and 251 cases of heart disease, stress disorders, and hypertension (8%).

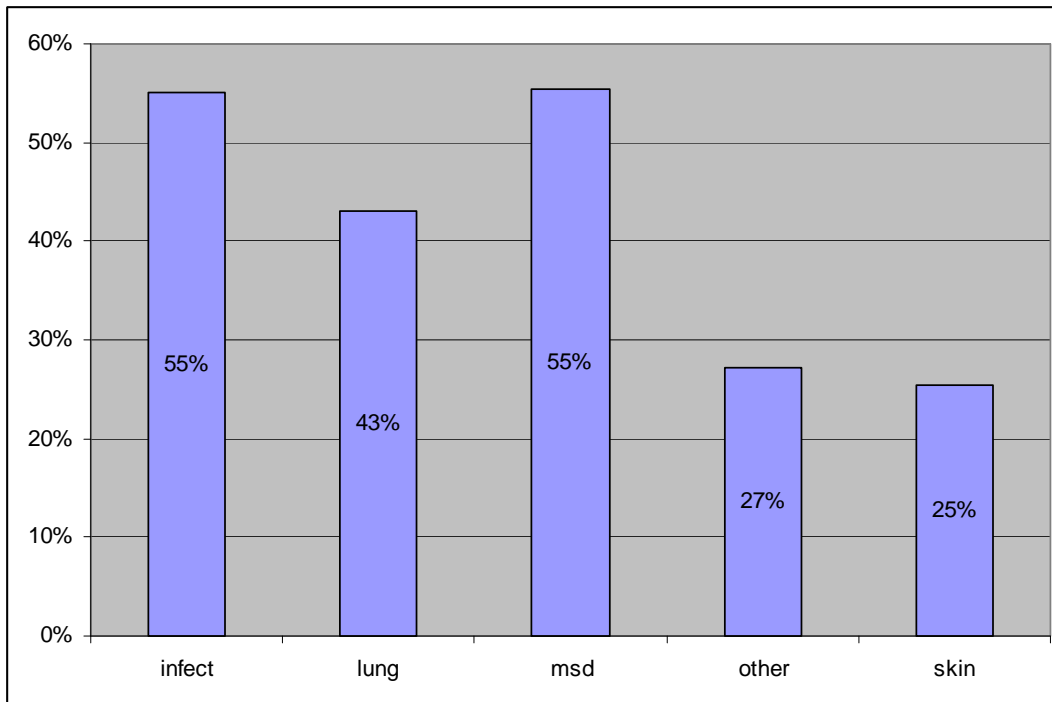
Figure D-1: Rate of Occupational Disease by Type, WCC, 1996-2005



Rate per 10,000 workers, not adjusted for hours worked.

*2003 may be an incomplete database

Figure D-2: Percent of Women by Disease Type, WCC, 2005



Overall, 47% of reports were by women, but this varied by type of case (Figure D-2), with higher proportions of women for MSD and infectious, but lower levels for skin, “other”, and lung.

Figure D-3 Occupational Illness Cases by Industry, WC, CT, 2005

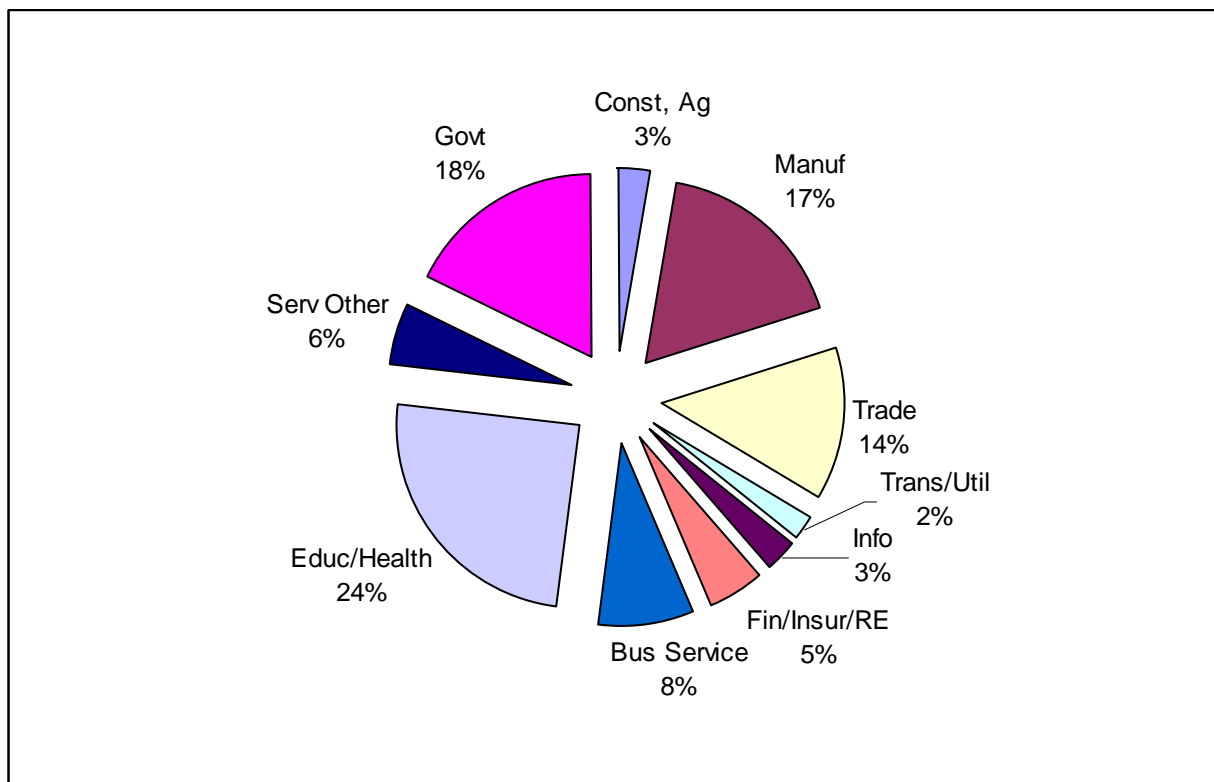


Table D-2: Cases/Rates of Occupational Disease by Major Industry Sector, WCC, 2005

NAICS Sector	Cases	Percent	Employ	Rate
Construction/Ag/Mine	77	3%	71,800	10.7
Manufacturing	512	18%	196,000	26.1
Trade	395	14%	259,300	15.2
Transport/Utilities	63	2%	49,400	12.8
Information Services	82	3%	38,400	21.4
Finance/Insurance/RE	145	5%	141,900	10.2
Business Services	242	8%	198,900	12.2
Education/Health	716	25%	265,700	26.9
Leisure/Other Services	162	6%	178,100	9.1
Government*	522	18%	214,600	24.3
Unknown	92			
Total	3008		1,614,100	18.6

Notes: Employment is not adjusted for hours worked. Rows do not add up to total due to reports that could not be coded for industry. Rates are per 10,000 employees.

*Government illnesses do not include those that are classified under other categories, such as education and health services.

Numbers and rates of occupational illnesses are presented by major NAICS industry sector in Figure D-3 and Table D-2. Ninety seven percent (97%) of reported cases were able to be coded for major industry sector. State and local government had the highest number of cases (943 or 31% of all cases), once accounting for other government cases allocated to other sectors such as education; there were 522 that were not included under education and other sectors. Only 49 of these reported cases were for

state government; all the others were for local government. This latter figure for State Government seems very low for the state sector except for 2004, which historically has much higher numbers (252 in 2003), and may indicate some reporting artifact. Education and health had 716 cases (which includes 410 government employees). Manufacturing had the next highest number of reports with 512, followed by Wholesale and Retail Trade (395 cases) and then Business Services (242 cases).

The rate per 10,000 workers factors in the size of employment in each sector. Education and Health (dominated by local government employees) was the highest rate at 26.9 per 10,000 workers, followed closely by Manufacturing (26.1) and general Government (primarily local government) at 24.3.

Table D-3 provides the detail of industry sector by type of condition, breaking out state and local government from the other sectors.

Table D-3: Type of Disease by Industry Sector, WCC, 2005

Industry	Infectious		Lung		MSD		Skin		Other	
	Cases	Percent	Cases	Percent	Cases	Percent	Cases	Percent	Cases	Percent
Con/Ag/Mine	2	0.4%	10	2.8%	44	3.0%	9	4.3%	12	2.4%
Manuf	2	0.4%	41	11.4%	359	24.2%	31	14.9%	79	15.6%
Trade	9	2.0%	34	9.5%	284	19.1%	14	6.7%	54	10.7%
Transp/Util	1	0.2%	3	0.8%	48	3.2%	5	2.4%	6	1.2%
Info	2	0.4%	3	0.8%	63	4.2%	7	3.4%	7	1.4%
Fin/Insur/RE	4	0.9%	16	4.5%	89	6.0%	5	2.4%	21	4.2%
Business Services	36	8.0%	18	5.0%	150	10.1%	16	7.7%	22	4.3%
Educ/Health	117	26.0%	35	9.7%	123	8.3%	7	3.4%	24	4.7%
Arts/Food Services	17	3.8%	19	5.3%	68	4.6%	14	6.7%	44	8.7%
Local Govt	253	56.2%	163	45.4%	183	12.3%	96	46.2%	199	39.3%
State Govt	1	0.2%	8	2.2%	13	0.9%		0.0%	27	5.3%
Unknown	6	1.3%	9	2.5%	61	4.1%	4	1.9%	11	2.2%
Total	450	100.0%	359	100.0%	1485	100.0%	208	100.0%	506	100.0%

Patterns of illness by industry differed by the type of illness (see Table D-3), although Local Government was high in all categories, particularly when including the Education sector. Infectious diseases were concentrated in Local Government (56%) and Health/Education (26%). Lung diseases were concentrated in Local Government (45%) and Manufacturing (11%). Musculoskeletal disorders were most prevalent in Manufacturing (24%), followed by Trade (19%), and Local Government (12%). Skin cases were most common in Local Government (46%) and Manufacturing (15%). Other Illnesses, which includes heart and hypertension cases as well as other illnesses (see below) were most common in Local Government (39%), Manufacturing (16%), and Trade (11%). These figures are based on numbers of cases and not rates, so they are not adjusted for the employment size in the different sectors.

Table D-4: Specific Industry Sectors with over 30 Cases of Occupational Disease, WCC, 2005

Specific Sector	NAICS	Cases	Change	Employ	Rate
Local Government		894	-27%	155500	57.5
Telecommunications	517	69	21%	13200	52.3
Transportation Equipment Manufacturing	336	187	-20%	43400	43.1
Electrical Equipment, Appliance, and Component Manufacturing	335	35	-33%	10500	33.3
Educational Services	611	407	24%	134800	30.2
Couriers and Messengers	492	21	-54%	7200	29.2
General Purpose Machinery Manufacturing	333	50		18300	27.3
Merchant Wholesalers, Nondurable Goods	424	56	10%	21600	25.9
Fabricated Metal Product Manufacturing	332	74	-41%	33800	21.9
Merchant Wholesalers, Durable Goods	423	63	-13%	31200	20.2
Nursing and Residential Care Facilities	623	107	9%	57100	18.7
Miscellaneous Manufacturing	339	23	-26%	12400	18.5
Computer and Electronic Product Manufacturing	334	26	-38%	15100	17.2
Hospitals	622	83	-15%	55800	14.9
General Merchandise Stores	452	38	-41%	25900	14.7
Personal and Laundry Services	812	28	-24%	19100	14.7
Social Assistance	624	43	5%	34600	12.4
Credit Intermediation and Related Activities (Banks)	522	35	-55%	31900	11.0
Ambulatory Health Care Services	621	76	4%	72200	10.5
Insurance Carriers and Related Activities	524	68	-30%	65200	10.4
Specialty Trade Contractors	238	47	-4%	46000	10.2
Food and Beverage Stores	445	41	-21%	42800	9.6
Amusement, Gambling, and Recreation Industries	713	24	-77%	26100	9.2
Non residential construction	236	11	-66%	14000	7.9
Food Services and Drinking Places	722	44	22%	93300	4.7
Administrative and Support Services	561	113	6%		
Professional, Scientific, and Technical Services	541	90	-1%		
Wholesale Electronic Markets and Agents and Brokers	425	64			

*Local government includes cases that may also appear in other specific sectors, such as educational services. Some employment figures (and therefore rates) are not available due to either out-of-range benchmark or sampling error thresholds.

Table D-4 shows those specific industry (3-digit NAICS code) sectors that reported over 30 cases of occupational illness either in 2004 or 2005. The list is ordered by the sectors with the highest rates listed first. Local government had by far the largest number of illnesses at 894 reports, which was, however, a 27% decrease from 2004, and which includes many of the 407 cases that are also shown under Educational Services.

Telecommunications had the next highest rate (52.3), followed by Transportation Equipment Manufacturing (43.1), Electrical Equipment Manufacturing (33.3), Couriers and Messengers (29.2), General Purpose Machinery Manufacturing (27.3), and Merchant Wholesalers (25.9).

In terms of overall numbers of cases, Local Government was followed by Educational Services (407 cases), Transportation Equipment Manufacturing (187), Administrative and Support Services (113), and Nursing and Residential Care Facilities (107).

Several industries reported much lower numbers of cases in 2005 than 2004. These included Amusement, Gambling, and Recreation Industries with a 77% decline, Non Residential Construction (66% decline), Credit Intermediation and Related Activities (Banks) (55% decline) and Couriers and Messengers (54% decline).

Musculoskeletal Disorders (MSDs)

“Musculoskeletal disorders” is the currently-used term for conditions also known as cumulative trauma disorders or repetitive strain injuries. There were 1,485 MSDs reported in 2005, a decrease of 30% over 2004. MSDs accounted for approximately half of the reported occupational diseases to Workers’ Compensation. MSDs presented here do not include any cases for the lower back, (since the descriptions of back conditions are typically not sufficient to be able to distinguish between acute and cumulative back injuries), nor do MSDs include any acute injury condition from sudden events.

Carpal Tunnel Syndrome (CTS), which is a pinching of the median nerve at the wrist, was the most common specific diagnosis with 254 cases reported, or 17% of total MSD reports, for a decrease of 36% over 2004 (Table D-5). Other nerve-related problems (with symptoms of numbness or tingling) accounted for an additional 64 cases, with an increase of 16%. Tendon-related problems included 55 cases of tendonitis and tenosynovitis, 18 cases of ganglion cysts, and 12 cases of epicondylitis (“tennis elbow” or “golfer’s elbow”). There were 8 cases of trigger finger. A large number (1,069) of cases did not have a specific description other than “pain”, “inflammation”, “strain or sprain” (this category does not include acute strains or sprains), or no description

Table D-5: Musculoskeletal Disorders (MSDs) by Type, WCC, 2004-5

MSD Type	2004	2005	%	Change
Strain/sprain	1,136	683	46%	-40%
Carpal Tunnel Syndrome (CTS)	397	254	17%	-36%
Inflammation	116	144	10%	24%
Numbness/Tingling	55	64	4%	16%
Tendonitis	62	55	4%	-11%
Pain	88	52	4%	-41%
Ganglion/cyst	23	18	1%	-22%
Epicondylitis	25	12	1%	-52%
Trigger finger	13	8	1%	-38%
Arthritis/Bursitis	7	5	0%	-29%
Other MSD	192	190	13%	-1%
Total	2,114	1,485	100%	-30%

Almost all the cases of MSD were in the upper extremity of the body (note that lower back cases were excluded from these figures). Almost half (45%) of total MSD cases were for the hand, wrist, and lower arm (see Table D-6). Other affected parts of the body included 8% elbow and 18% shoulder, neck, and “upper extremity”. Only 8% were for the legs, knees and feet.

Table D-6: Musculoskeletal Disorders by Part of Body, WCC, 2005

Part of body	Cases	Percent
Lower Arm, Wrist, Hand	672	45%
Upper Arm, Shoulder, Upper Extremity	270	18%
Legs, Knees, and Feet	114	8%
Elbow	113	8%
Neck and Upper Back	50	3%
Multiple	234	16%
Other/Unknown	32	2%
Total	1485	100%

Causes of conditions were often incomplete and not consistently coded nor described. Approximately two-thirds of MSD cases had enough description to show some cause. Of the MSDs that could be classified, the most frequently mentioned cause was the broad category of “repetition” (334 cases), although this was frequently just from a general description, and often used to describe any chronic musculoskeletal problem (see Table D-7). This was followed by lifting (159 cases) and computing and clerical tasks that included typing, keying, mouse use, phone use, etc, with 140 cases (a drop of about one-third from last year). There were 107 cases that mentioned use of some type of tool, including many references specifically to pneumatic tools that have been associated with vibration exposure as well as biomechanical risks. Machine use was mentioned in 45 cases, pushing or pulling in 40, and assembly tasks in 23.

Table D-7: Causes of Musculoskeletal Disorders (MSD), WCC, 2005

Cause of MSD	Reports	Cause of MSD	Reports
Repetitive	334	Cleaning	14
Lifting	159	Packing	13
Computer	140	Kneeling	12
Tools	107	Gripping	11
Machine	45	Twisting	11
Push/Pull	40	Standing	10
Assembly	23	Reaching	9
Driving	19	Patient Care	8
Selecting/sorting	16	Shoveling	7
Walking	15	Cashier	7

Infectious Diseases

There were a total of 450 reports of infectious diseases or exposures in 2005 (Table D-8), a decrease of 24% from 2004 (after a 171% increase last year). There were decreases in almost all categories of infectious reports. Overall, there was a 12% decrease in reports of bloodborne disease and exposures from blood, body fluids, bites, and needlesticks, but this included a 56% increase in the most serious category of needlestick and sharps injuries. There was a 22% decrease in Lyme disease or tick bites, a 51% decrease in TB exposures or PPD tests, and a 30% decrease in other infectious diseases. There was a sharp (94%) decline in reports of exposure to meningitis after a major cluster in one workplace in 2004.

Infectious disease reports include both actual disease and exposure to potentially infectious agents. Recent court decisions have broadened the definition of compensable disease to include exposures, particularly where exposure requires medical treatment such as prophylactic treatments such as for tuberculosis (TB) and AIDS (HIV) exposures. There has recently been considerable attention paid to Lyme Disease among outdoor workers, resulting in more reports of tick bites. It is often difficult to determine whether the first report of injury was actual disease or only exposure (for example, actual Lyme Disease or only a report of a tick bite). Similarly, it is usually not clear in the reports for needlestick and sharps injuries whether the source patient or client was actually infected with any of the known bloodborne diseases. There were additional reports of exposure to “spit” or “sputum” that are not reported here, since risks tend to be very low from such exposures. Diseases that can be contracted through blood and body fluid exposures include hepatitis B, C and HIV. Human bites or exposures to body fluids such as urine are also related to bloodborne diseases. Transmission is much less likely when a worker is exposed to urine or a human bite than transmission occurring from blood, particularly for HIV. Blood to blood exposure is the highest risk, such as from needlesticks or sharps injuries. Altercations or arrests with prisoners or clients accounted for the vast majority of human bites as well as some of the other bloodborne exposures.

Table D-8: Infectious Diseases and Exposures by Type, WCC, 2004-5

Illness	2004	%	2005	%	% Change
Blood/body fluids	167	28%	113	25%	-32%
Sharp and needlestick exposures	66	11%	103	23%	56%
Human bite/Urine	145	25%	118	26%	-19%
Lyme Disease/Tick bite	50	8%	39	9%	-22%
TB/ppd conversion/exposure	49	8%	24	5%	-51%
Meningitis exposure	31	5%	2	0%	-94%
Scabies	19	3%	7	2%	-63%
Other infectious	63	11%	44	10%	-30%
Total	590	100%	450	100%	-24%

There were 39 reports of tick bites, rashes from tick bites, and Lyme Disease attributed to occupational exposures. There were 24 cases of tuberculosis infection (PPD conversion) or exposures to clients with TB. There were also 44 other infectious diseases or exposures reported, including reports relating to rabies exposure (7), MRSA (3 cases), ringworm (2), shingles, Fifth Disease, and rabies.

There were 10 reports of leptospirosis exposure from workers at a veterinarian facility. Leptospirosis is a bacterial infection that can be transmitted from animals to humans through contact with an infected animal’s urine.

Acute Respiratory Conditions and Poisonings

There were 256 cases of acute respiratory conditions reported for 2005 and 44 cases of poisonings from carbon monoxide, pesticides, mercury, lead, or other causes, overall a 53% increase over 2004. Because descriptions vary, causes are difficult to precisely classify (see Table D-9). Chemical exposures were the most common cause of illness, followed by exposure to fumes, smoke, cleaning products, and construction or painting. See below for chronic lung conditions.

Table D-9: Acute Respiratory Conditions and Poisonings by Cause, WCC, 2004-5

Cause	2004	%	2005	%	% Change
Respiratory					
Chemical Exposure	43	22%	92	31%	114%
Fumes Exposure	35	18%	31	10%	-11%
Smoke, Fire	30	15%	30	10%	0%
Cleaning	13	7%	21	7%	62%
Construction/paint	5	3%	19	6%	280%
Odor	10	5%	8	3%	-20%
Dust	5	3%	2	1%	-60%
Other Respiratory	22	11%	53	18%	141%
Poisoning					
Carbon monoxide/gas	8	4%	25	8%	213%
Mercury/lead	5	3%	14	5%	180%
Pesticides	13	7%	1	0%	-92%
Other Poisoning	2	1%	4	1%	100%
Total	196	100%	300	100%	53%

Chemical exposures mentioned included glue, solvents, ink, wood finish, foam, carpet spot remover, carpet cleaner with glycol ether acetate, toner, polymer, fragrance, fire extinguisher (4), bleach, printing fumes, roach bombs, methacholine (2), acid (2), and mace. One respiratory condition was attributed to an allergy to “the smell of money”. There was a cluster of 29 cases of chlorine gas exposure to firefighters who were attempting to control a leak.

Chronic Lung Conditions

There were 59 cases of chronic lung conditions in 2005, a decrease of 58% from 2004 (after an increase of 67% from 2003). These included asbestos-related diseases and exposures, occupational asthma, and other chronic lung diseases. Acute lung diseases are classified under respiratory disease (above). Most allergies, such as those caused by latex or mold, that often include lung effects, are included under “Other occupational diseases” below, although those that are described as having specific lung effects are shown here (under “other lung”).

Asbestos

There were 16 reports of asbestos-related disease or exposures in 2005 (Table D-10). The descriptions of the cases often made it difficult to determine whether the cases were actual disease or only exposure to asbestos, although there was at least one fatality and one asbestosis case described. Asbestos exposure is known to increase the risk of lung disease and cancer. If disease occurs as a result, it often appears between 10-40 years after exposure. Asbestos disease may be under-reported by traditional surveillance sources such as Workers’ Compensation. Industries for asbestos conditions included shipyards, hospital, construction, telecommunications, and the state.

There were 22 occupational asthma cases reported in 2005. Causes included cleaning chemicals, perfume, and indoor air quality.

“Other lung” conditions included 21 reports of other or poorly-described respiratory conditions (including headaches, sore throat, respiratory irritation, dizziness, vomiting, heart palpitations, colds, respiratory infections, allergies and difficulty breathing) due to indoor air quality issues. Eight cases specifically note mold as a cause. One case reports a cranial hematoma due to the indoor air quality.

Table D-10: Chronic Lung Diseases by Type, WCC, 2004-5

Illness	2004	2005	% Change
Asbestos-related	35	16	-54%
Asthma	27	22	-19%
Other lung	77	21	-73%
Total	139	59	-58%

Skin Conditions

There were 208 skin conditions reported in 2005, a 6% decrease from 2004. There were 100 cases of contact dermatitis from poison ivy or other plants, with 7 cases that were specified as allergic reactions (some categorized by the substance that caused it). There were 15 cases of allergic reactions to latex, gloves, or other clothing. There were 21 cases caused by chemicals (including solvents, reagents, adhesives, chromium, cleaning agents and soaps, powder, epoxy, weed killer, methanol, fiberglass, tape, contaminated water, and shrimp (Table D-11).

Table D-11: Skin Diseases by Cause, WCC, 2004-5

Category	2004	2005	%	% Change
Poison Ivy/plants	109	100	48%	-8%
Chemical	20	21	10%	5%
Gloves/Latex/clothing	11	15	7%	36%
Coolant/Oil/machine	9	14	7%	56%
Allergic	13	5	2%	-62%
Soap/Cleaning	11	10	5%	-9%
Dusts/Metals	5	5	2%	0%
Other/Unknown	44	38	18%	-14%
Total	222	208	100%	-6%

Stress and Heart Conditions

Heart and Hypertension

There were 251 cases involving heart conditions, stroke, chest pain, hypertension, or stress reported in 2005, a decrease of 27% over 2004 (Table D-12 and D-13). Thirty-six (36) cases specifically mentioned heart attacks or myocardial infarctions (several noting a fatality), 11 described a physician diagnosis of heart problems, 5 reported strokes or clots, 102 described symptoms of chest pain, often associated with emergency care at a hospital. There were 36 cases that described the condition as hypertension or “heart and hypertension” (the usual legal term for heart or hypertension cases that are covered for police and fire fighters).

Though not generally well described, causes of the heart cases included multiple cases due to physical exertion including lifting and unloading, shoveling snow, responding to emergencies or altercations, job stress, and firefighting. Approximately 120 of the cases involved police or firefighters or

municipal employees who are frequently covered under heart and hypertension laws that consider those conditions to be work-related for workers' compensation purposes.

Table D-12: Heart and Hypertension Conditions by Type, WCC, 2004-5

Category	2004	%	2005	%	% Change
Heart Attack	38	15%	36	19%	-5%
Heart diagnosis	24	9%	11	6%	-54%
Chest pain/symptoms	93	36%	102	54%	10%
Stroke	10	4%	5	3%	-50%
Hypertension	93	36%	36	19%	-61%
Total	258	100%	190	100%	-26%

Mental Stress

There were a total of 61 stress-related claims in 2005, a 29% decrease from 2004. There were 11 cases which cited reactions to violence or robbery, 8 which were ascribed to job demands and workload, 6 cases related to harassment, 9 cases that were attributed to conflicts with supervisors or co-workers. Six cases were described as depression or anxiety. There were 21 that included reactions to being trapped in an elevator, loud noise, or other reports which were simply defined as "stress" without further explanation (See Table D-13). There were also several stress-related cases that are classified under heart conditions (See Table D-12, above).

Table D-13: Stress Conditions by Source, WCC, 2004-5

Sources of Stress Conditions	2004	2005
Violence/robbery	8	11
Supervisor/co-worker conflict/disciplinary action	10	9
Job Demands & workload	8	8
Harassment/ hostile environment	10	6
Depression/anxiety	7	6
Unknown/other	43	21
Total	86	61

Other Occupational Diseases

Hearing Loss

There were 78 cases of hearing loss in 2005 (Table D-14), an decrease of 31% over 2004. Of these cases, 13 appeared to be caused by acute noises or injuries (such as very loud noises such as gunfire). The rest appeared due to long-term exposure to noise, mostly from manufacturing workplaces, or were noted as being found on routine audiograms.

Table D-14: Other Occupational Illnesses, WCC, 2004-5

Type of illness	2004	2005	%	Change
Hearing loss	117	78	31%	-33%
Dizziness/passing out	45	67	26%	49%
Cold/heat related conditions	26	55	22%	112%
Allergic	19	8	3%	-58%
Cancer	6	3	1%	-50%
Other conditions	49	44	17%	-10%
Total	262	255	100%	-3%

Other Disease Conditions

There were 55 reports of temperature-related problems from heat or cold (with all but 7 due to heat). There were 67 reports of workers becoming dizzy, fainting, or similar conditions such as seizures.

There were 8 cases of allergic reactions reported in addition to those noted above under lung and skin conditions attributed to foods.

There were 3 cases of cancer reported, two attributed to chemicals and 1 attributed to asbestos.

There were 44 “other” conditions, some of which were very serious. These included a number of reports of acute vomiting and/or collapse, a report of bloodclot moving to the lung due to lack of movement on the job, a brain aneurism, a problem with voice and throat, and vomiting up blood.

E. Occupational Disease Surveillance System (Physicians' Reports)

Physicians are required to report known and suspected occupational disease to the Occupational Disease Surveillance System that is maintained by the Departments of Labor and Public Health. Although all physicians are required to report, most reports are received from the occupational health clinics and industrial medicine programs.

There were 1,043 occupational illness reports received from physicians in 2005, an increase of 13% from 2004 (Table E-1), with an additional 463 reports of lead poisoning cases through the laboratory reporting system. Overall, there was a 19% increase in disease reports, including the 35% increase in lead reports. There were increases in all categories of illness except Infectious disease (note that bloodborne diseases are not captured in the ODSS system), including a 24% increase in skin condition, a 10% increase in lung conditions, a 5% increase in musculoskeletal (MSD) cases, and a 94% increase in "Other" illnesses.

Table E-1: Occupational Disease by Type, ODSS, 1998-2005

Category	1998	1999	2000	2001	2002	2003	2004	2005	% Change 2004-5
MSD	754	823	1174	841	921	624	488	511	5%
Skin	237	295	339	274	338	181	194	241	24%
Lung	206	139	291	190	283	156	173	191	10%
Other	31	31	74	56	30	20	36	70	94%
Infectious*	13	22	27	68	34	21	33	30	-9%
Sub-total ODSS	1,241	1,310	1,905	1,429	1,606	1,002	924	1,043	13%
Lead (Lab)	203	212	616**	530**	476**	400**	342**	463**	35%
Total	1,444	1,522	2,521	1,959	2,082	1,402	1,266	1,506	19%

*Does not include bloodborne pathogens exposure

** Lead values for 2000 - 2004 include cases in the blood lead level range of 10-19ug/dl that were not included in prior years.

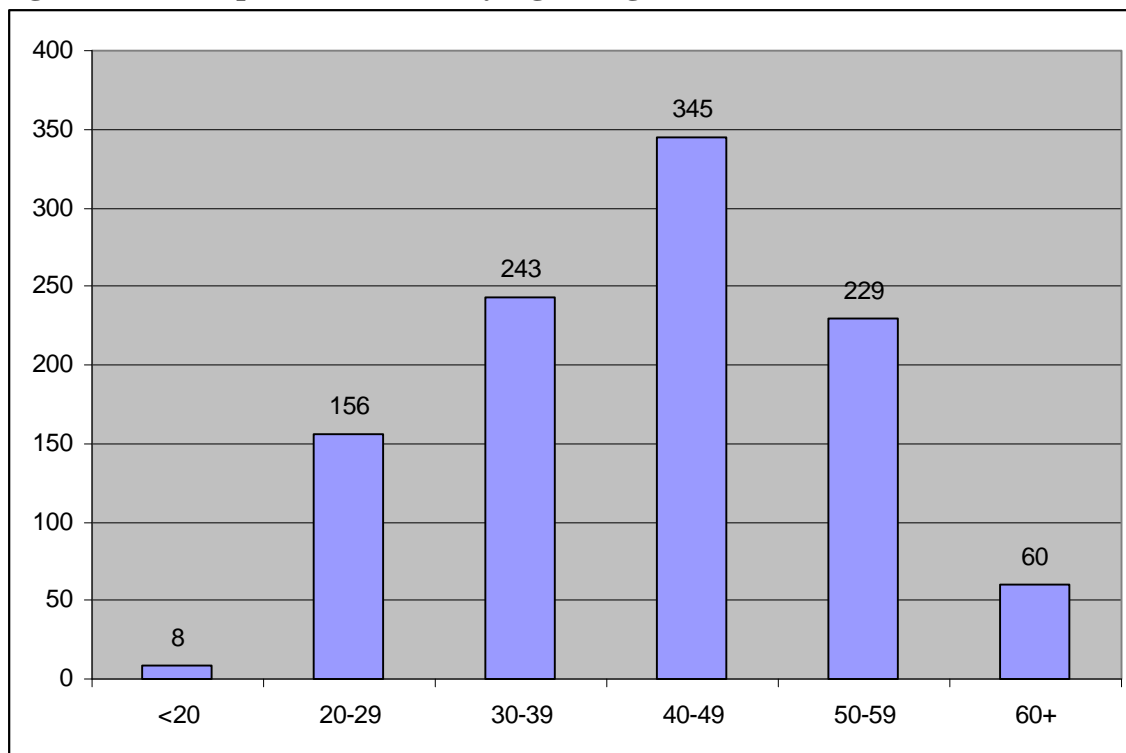
In 2005, 76 physicians from 22 clinics (at 27 locations) reported at least one case into the ODSS system, approximately the same numbers as in previous years. Six clinics contributed two-thirds of the cases. Although it is a state law that known and suspected occupational diseases diagnosed by any physician in the state must be reported to this system (CGS § 31-40a), the primary reporters are the occupational health clinics and auxiliary occupational health clinics. Therefore, these reports should be viewed as just a small portion of physician-diagnosed occupational diseases in Connecticut.

Physicians only reported on whether exposures causing the condition were continuing for approximately 25% of the reports; of these, 43% of cases were known to have continuing exposure. In 43% of the cases it was reported that other workers were likely to be exposed to the same hazard (where this was known). Sixty-two percent (62%) of the cases were classed as "high certainty" for being an occupationally-related disease, 31% were "moderate certainty," and 7% "low certainty."

Of the 682 cases where race was known, 96 (14%) were identified as Black, and 77 (8%) of 912 cases (where ethnicity was known) were identified as Hispanic.

The largest number of cases were in the age range of 40-49 years old (33% of all cases), followed by those in their 30's (23%), 50's (22%) and 20's (15%; Figure E-1). Only 8 cases were reported in workers less than 20 years of age.

Figure E-1: Occupational Disease by Age Range, ODSS, 2005



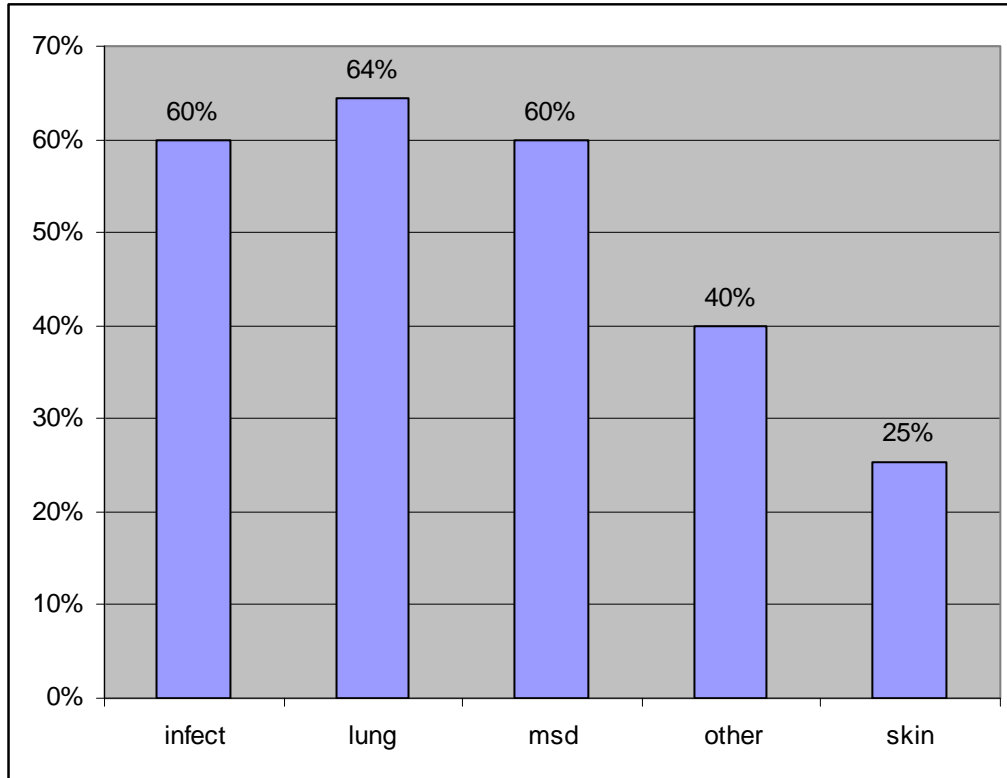
Patterns of age were different for different types of illness (Table E-2). Skin conditions and infectious diseases affected mainly in their 20's and 30's (30% each), while lung disease, MSD, and other cases were on average somewhat older, with the largest number in the 40-49 year range. Skin diseases were distributed relatively evenly from the 20's to 50's.

Table E-2: Occupational Disease Type by Age, 2005

Age	Infectious	Lung	MSD	Other	Skin
<20	3%	0%	0%	3%	1%
20-29	30%	9%	10%	13%	28%
30-39	30%	19%	24%	27%	24%
40-49	20%	38%	35%	33%	27%
50-59	17%	27%	23%	20%	17%
60+	0%	6%	7%	4%	3%
Total Cases	100%	100%	100%	100%	100%

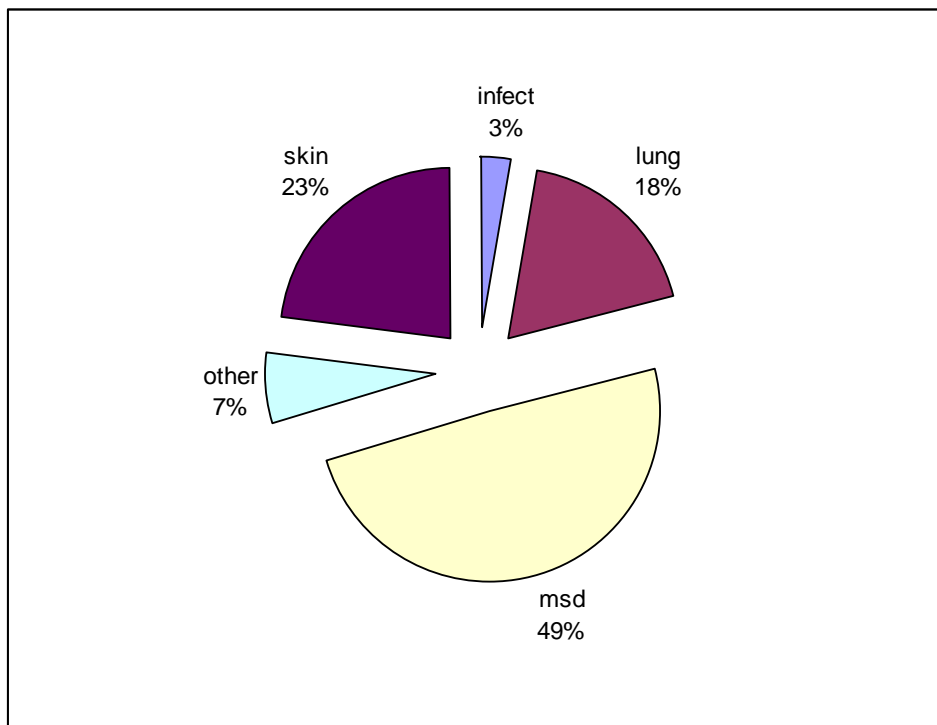
Overall, cases were virtually evenly distributed by gender, with 51% of cases being female. However, this differed somewhat by condition: 60% or more of MSD, lung, and infectious reports were for women, but only 25% of skin disease and 40% of "Other Illness cases were female (Figure E-2).

Figure E-2: Percent Female by Illness Type, ODSS, 2005



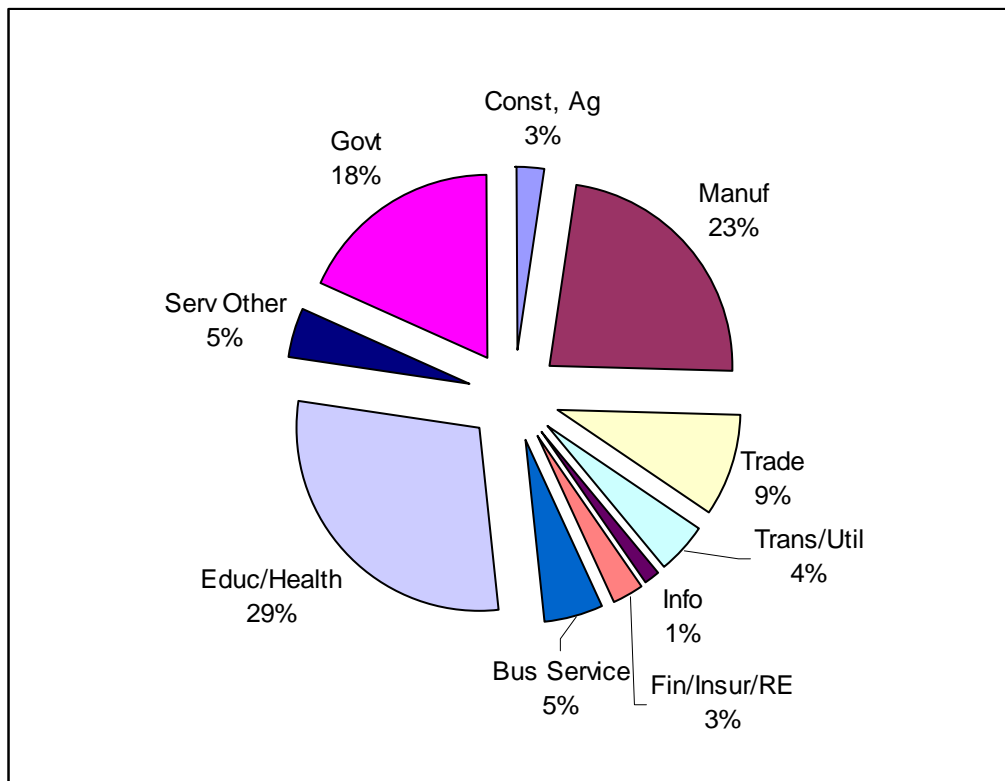
Reports were dominated by musculoskeletal disorders (MSD; 49%), followed by skin (23%), lung/respiratory (18%), infectious (3%), and “other” conditions (see Figure E-3). Lead cases are not included in the figure since they are from a different type of reporting system.

Figure E-3: Occupational Disease by Type, ODSS, 2005



Reported cases were predominately from the Education and Health sector (29%), followed by Manufacturing (23%) and Government (18%) (Figure E-4).

Figure E-4: Occupational Disease by Industry Sector, ODSS, 2005



However, industry distribution was somewhat different by condition (Table E-3). Overall, the largest numbers of reports were from Education and Health (29%), State and Local Government (18%; Education and Health also includes government workers), and Manufacturing (23%). However, 30% of MSD (Musculoskeletal Disorders) was from Manufacturing, with lower numbers for Government; Trade had somewhat higher levels of MSD, as did Information in comparison to overall averages.

Table E-3: Type of Illness by Industry Sector (SIC), 2005

Industry	Total	Infectious	Lung	MSD	Other	Skin
Const, Ag	3%	0%	1%	1%	3%	7%
Manufacturing	23%	3%	13%	30%	19%	21%
Trade	9%	0%	8%	12%	6%	4%
Trans/Utility	4%	7%	3%	5%	3%	3%
Info	1%	0%	0%	2%	1%	0%
Fin/Insur/RE	3%	0%	2%	5%	1%	0%
Bus Service	5%	0%	6%	5%	7%	6%
Educ/Health	29%	24%	31%	27%	30%	31%
Service Other	5%	48%	2%	3%	4%	4%
Government	18%	17%	34%	10%	26%	23%
Total Known	1,013	29	181	501	70	232
Unknown	30	1	10	10		9
Total	1,043	30	191	511	70	241

Musculoskeletal Disorders (MSDs)

Musculoskeletal Disorders (MSDs) increased slightly (by 4%) in 2005, after 2 years of decline. This figure only includes upper-extremity MSD (does not include MSD caused by acute incidents such as falls or individual lifts), and excludes lower back diagnoses, even if caused by cumulative strain. The most common specific diagnoses for musculoskeletal disorders were Carpal Tunnel Syndrome (27% of all reports), tendonitis (13%), epicondylitis (13%), and the less specific category of strain or sprain (14%) (Table E-4; also see descriptions of conditions below). The increase was driven by a 45% increase in Carpal Tunnel Syndrome, 59% increase in “other MSD”, and a 25% increase in tendonitis. This was balanced by decreases in epicondylitis (-33%), DeQuervains Syndrome (-31%), and ganglion cysts (-22%).

Table E-4: Musculoskeletal Disorders by Type, ODSS, 2005

Illness	Cases	%	% Change
Carpal Tunnel Syndrome (CTS)	135	27%	45%
Strain/Sprain	71	14%	-10%
Tendonitis	67	13%	-7%
Epicondylitis	64	13%	-33%
Other MSD	59	12%	59%
Tenosynovitis	30	6%	25%
DeQuervains	22	4%	-31%
Bursitis/Arthritis	16	3%	-36%
Ganglion	14	3%	-22%
Cubital/Radial Tunnel Syndrome	13	3%	18%
Trigger Finger	11	2%	
Thoracic Outlet Syndrome	7	1%	
Total	509	100%	4%

Musculoskeletal disorders (also referred to as cumulative trauma disorders or repetitive strain injuries) include tendon-related conditions, nerve problems, circulatory, as well as combined conditions. Specific descriptions of these disorders include:

Tendon Disorders

- Tendonitis: swelling of the tendons
- Epicondylitis: tendon irritation in the elbow area, including “golfer’s elbow” and “tennis elbow”
- Rotator Cuff Syndrome: tendonitis in the shoulder area
- Tenosynovitis: inflammation of the tendon sheaths, lubricated covers that surround the tendons, particularly in the hand
- De Quervain’s Syndrome: tendon sheath disorder of side of wrist and base of thumb
- Trigger Finger: a bump on the tendon that catches on the tendon sheath that makes the finger or thumb difficult to move
- Ganglion Cysts: swelling of the tendon sheaths from excess lubricating fluid
- Bursitis: inflammation of the fluid-filled sacs around ligaments and tendons

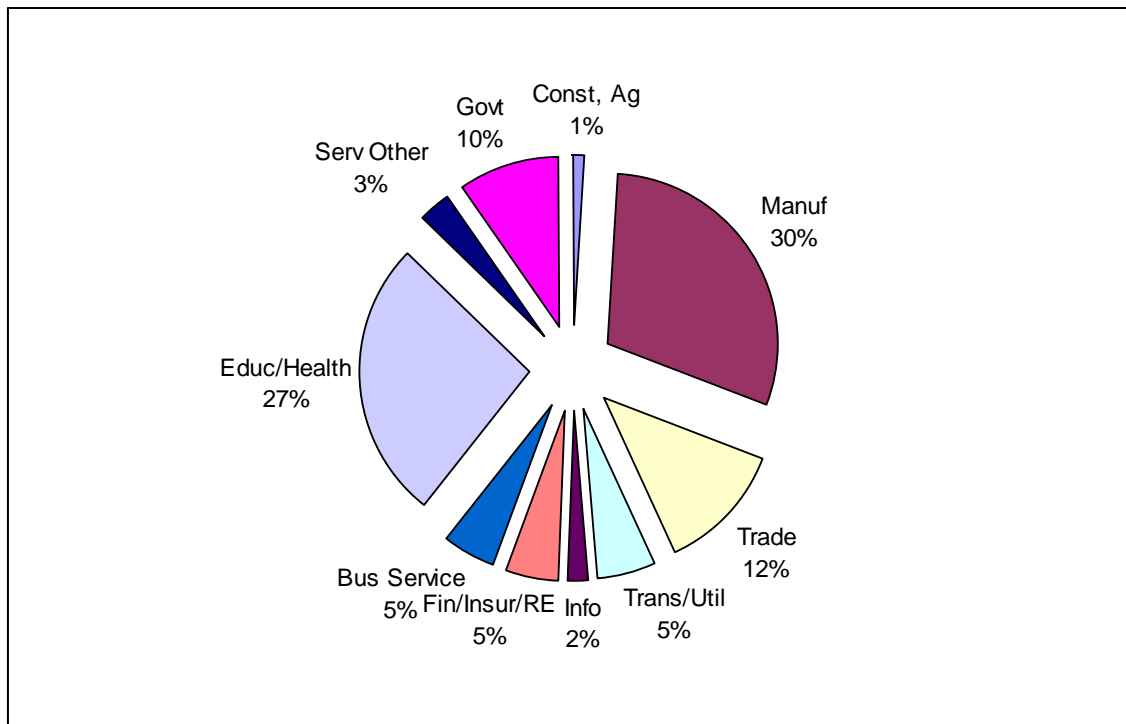
Nerve Disorders

- Carpal Tunnel Syndrome: pinching of the median nerve in the wrist, usually by swollen tendons that pass through the carpal tunnel (the median nerve can also be pinched in the elbow, shoulder, or neck areas)

Circulatory/Combined/Other

- Thoracic Outlet Syndrome: pinching of the nerves and blood vessels in the neck/ shoulder area

Figure E-5: Musculoskeletal Disorders by Industry Sector, ODSS, 2005



The largest number of MSDs was from the Manufacturing (30%), Education and Health (27%), Trade (12%) and Government (10%; public education is included under Education and Health) (Figure E-5).

Specific industries with 10 or more MSDs reported are shown in Table E-5. These included hospitals, metal manufacturing, nursing homes, transportation equipment, government, insurers, electrical equipment manufacturing, and ambulatory health services. It should also be noted that some of these industries include some of Connecticut's larger employers. Because of higher employment, larger employers and sectors are likely to have more reported cases.

MSD's are grouped by occupational category in Table E-6. The largest numbers were in Production occupations (28% of reports) and office and administrative support (20%).

Table E-5: Specific Industries with 10 or more MSDs Reported, ODSS, 2005

Specific Industry	NAICS	Cases
Hospitals	622	64
Fabricated Metal Product Manufacturing	332	36
Nursing and Residential Care Facilities	623	29
Transportation Equipment Manufacturing	336	24
Other government	921	23
Insurance Carriers and Related Activities	524	18
Electrical Equipment, Appliance, and Component Mfg	335	16
Ambulatory Health Care Services	621	15
Justice, Public Order, and Safety Activities (govt)	922	15
General Purpose Machinery Manufacturing	333	14
Food and Beverage Stores	445	14
Educational Services	611	14
Professional, Scientific, and Technical Services	541	13
Utilities	221	11
Merchant Wholesalers, Durable Goods	423	11
Social Assistance	624	11
Printing	323	10
Rubber and Plastics Mfg	326	10
Merchant Wholesalers, Nondurable Goods	424	10

Table E-6: MSD by Occupation, ODSS, 2005

Occupation	Code	Cases	%
Production	51	124	28%
Office and administrative support	43	86	20%
Construction and extraction	47	32	7%
Transportation and material moving	53	32	7%
Healthcare practitioners and technical	29	24	5%
Healthcare support	31	24	5%
Installation, maintenance and repair	49	17	4%
Sales and related	41	16	4%
Management	11	13	3%
Protective service	33	12	3%
Building and grounds cleaning and maintenance	37	11	3%
Business and financial	13	10	2%
Education, training, and library	25	9	2%
Food preparation and serving	35	9	2%
Computer and math	15	6	1%
Life, physical, and social science	19	4	1%
Community and social service	21	4	1%
Architecture and engineering	17	2	0%
Personal care and service	39	2	0%
Arts, design, entertainment, sports and media	27	1	0%
Total (Known)		438	100%

Table E-7: Common causes of MSD, ODSS, 2005

Cause	Cases
Repetition/cumulative	81
Computer	39
Lifting	24
Tools & Vibration	23
Push/pull	17

Causes for MSDs are also difficult to classify since they are frequently described differently. The most common causes noted for MSDs were “repetitive motions” or “cumulative” (81 reports), computer use and data entry (39) lifting (24), tools and vibration (23), and pushing or pulling (17) (Table E-7). “Repetitive motion” tends to be a common term to describe MSDs, which may not clearly indicate a cause.

Skin Conditions

Skin condition reports increased 24% to 241 cases in 2005 (Table E-8). The largest category was contact dermatitis (37%), followed by poison ivy or other plant exposure (25%) chemical dermatitis (14%), and cases labeled as allergic dermatitis (5%).

Table E-8: Skin Conditions by Type, ODSS, 2005

Illness	2005	Percent
Contact dermatitis	90	37%
Poison ivy & other plants	61	25%
Chemical dermatitis	33	14%
Allergic	11	5%
Uticaria	8	3%
Other dermatitis	32	13%
Other skin conditions	6	2%
Total	241	100%

Table E-9: Skin Conditions by Cause, ODSS, 2005

Cause	Cases	%
Poison ivy & other plants	61	44%
Chemical	25	18%
Cleaners & solvents	23	16%
Gloves/latex/clothing	13	9%
Oils	11	8%
Other/unknown	7	5%
Total	140	100%

The most common cause of skin conditions was poison ivy and other plant exposures with 61 cases, followed by chemicals (25), cleaners and solvents (23), latex, gloves and clothing (13), and coolants and oils (11) (Table E-9).

Skin conditions (Figure E-6) occurred most commonly in the Education and Health sector (32%), followed by state and local government (23%) and manufacturing (21%).

Figure E-6: Skin Conditions by Industry Sector, ODSS, 2005

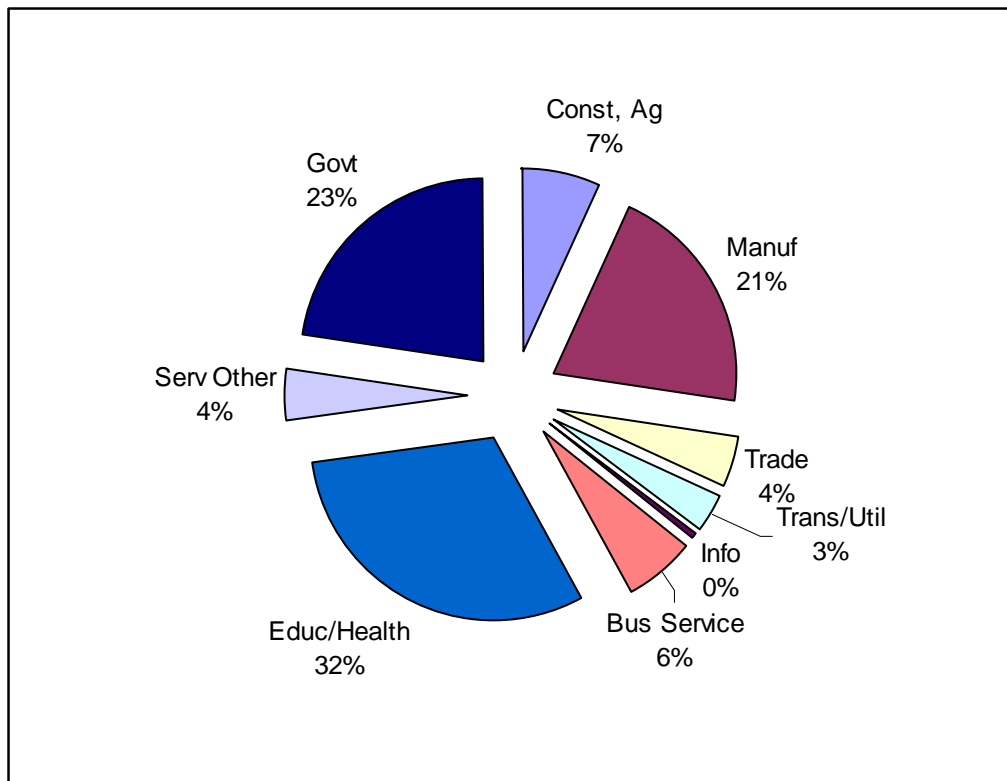


Table E-10: Clusters of Skin Disease by Specific Industry, ODSS, 2005

Specific Industry	NAICS	Cases
Other government	921	31
Hospitals	622	29
Justice, Public Order, and Safety Activities	922	20
Fabricated Metal Product Manufacturing	332	17
Nursing and Residential Care Facilities	623	17
Ambulatory Health Care Services	621	14
Educational Services	611	10

There were 7 specific industries in which at least 10 cases were reported (Table E-10): Government (both under “other government” and “justice, public order and safety” (including police and fire) had a total of 51 cases, followed by hospitals (29), fabricated metal manufacturing (17), nursing homes (17), ambulatory health care (14), and Educational services (10, which also includes a number of local government workers). Municipal cases included a number of Public Works employees coming into contact with poison ivy or other plants. The hospital and nursing home cases included latex or gloves as well as cleaning products or soaps/detergents.

Specific occupations for which at least 10 cases were reported included construction workers (40, mainly poison ivy), production workers (39, mainly oils, coolants, solvents and chemicals), building

and grounds maintenance (23, poison ivy, cleaning chemicals), protective service (22, some poison ivy but most not reported), healthcare practitioners (19, with cases of latex and clothing exposures), transportation and material moving (12, chemicals, cleaning, and poison ivy), and office and administrative support (10).

Lung Diseases and Poisonings

There were 191 cases of lung disease and poisonings reported in 2005, an increase of 10% from the previous year (following an 11% increase in 2004). The most commonly reported condition was acute respiratory disease (45%), typically caused by exposure to chemicals or fumes (Table E-11). Asthma and a similar condition called reactive airways dysfunction syndrome (RADS) was the next most common category (20%), an increase of 56% from 2004. There were 27 cases of rhinitis or sinusitis reported, a 125% increase, mainly due to indoor air quality problems. There were 17 cases of bronchitis reported, and 6 cases of hypersensitivity pneumonitis, which is a serious lung inflammatory response to bacteria or fungus, such as mold. There were only 3 asbestos-related conditions reported, a sharp drop of 85% from the previous year.

Table E-11: Lung Diseases and Poisoning by Type, ODSS, 2004-2005

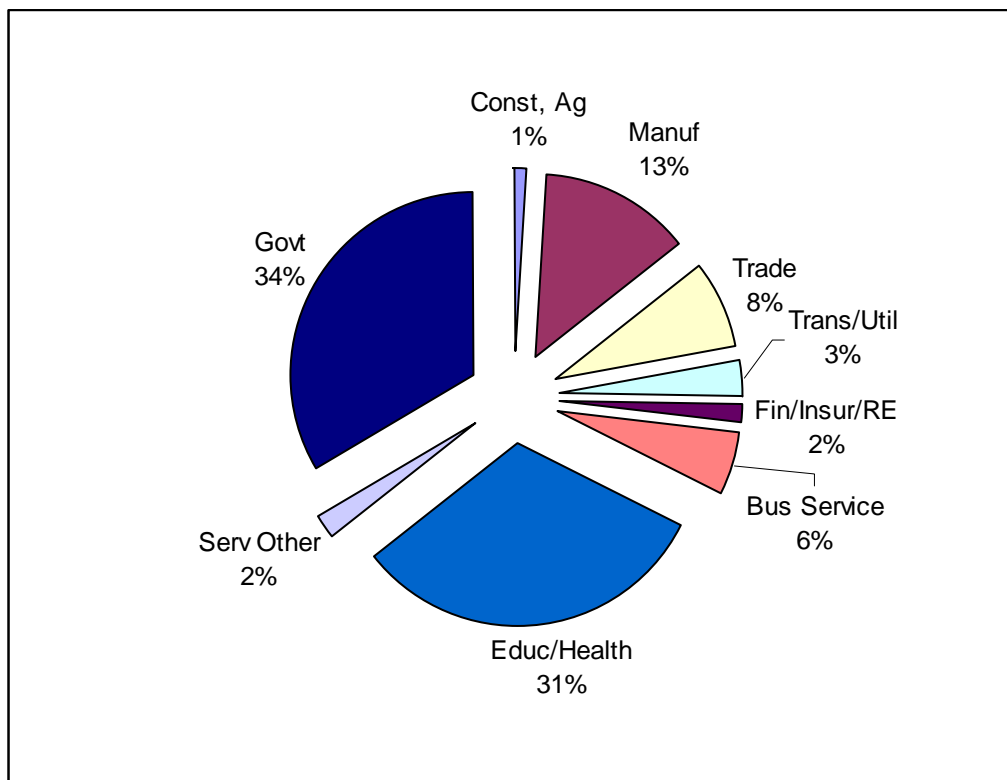
Illness	2004	2005	Percent
Respiratory	83	85	45%
Asthma/RADS	25	39	20%
Rhinitis/sinusitis	12	27	14%
Bronchitis	5	17	9%
Hypersensitivity Pneumonitis	0	6	3%
Multiple Chemical Sensitivity	2	4	2%
Asbestos-related	20	3	2%
Poisoning	11	2	1%
Allergy	3	1	1%
Other Lung	12	7	4%
Total	173	191	100%

Table E-12: Causes of Lung and Poisoning Conditions, ODSS, 2005

Cause of Lung Condition	Cases
Chemical	54
Mold	33
Fumes	30
Indoor air quality	21
Dust or construction	12
Cleaning	4
Asbestos	3
Smoke	3
Allergens	3
Odor	2

Causes of lung problems were highly varied (Table E-12). There were 54 reports of lung conditions due to chemicals (including xylene, spirit of peppermint, acetone, 2 butoxyethyl, 1,4 dichlorobenzene, acid, and alcohol), 33 due to mold specifically (about double that reported in 2004), 30 due to fumes, gases, and carbon monoxide, 21 due to indoor air quality problems (also a sharp increase over 2004), and 12 due to construction or dusts.

Figure E-7: Lung Disease by Industry, ODSS, 2005



Lung disease cases mainly occurred in Government (61 cases, or 34%), including 29 from state government, and Education and Health (31%), followed by Manufacturing (13%) and Trade (8%).

Lead Poisoning

There was a 35% increase in individuals with elevated blood lead levels reported in adults (after a 15% decrease last year) based on laboratory reports, increasing from 342 cases in 2004 to 463 cases in 2005. Increases occurred in almost all categories of lead levels. The lowest level (10-24 ug/dl) of lead levels accounted for 83% of all cases (Table E-13). Despite decreases, there were still 14 reports of blood leads of 40 or greater.

Connecticut requires laboratories to report all blood lead tests of 10 micrograms per deciliter of whole blood or greater to the Connecticut Department of Public Health (CGS § 19a-110). These cases are classified into childhood (less than 16 years of age) and adult cases (only the latter are reported here), with the majority of adult cases being attributed to an individual's occupation (although some cases occur in individuals engaged in hobbies such as home improvement or target shooting). OSHA medical removal protections apply at the level of 50 micrograms per deciliter of whole blood or above (40 micrograms per deciliter to return to work), although lead can have neurological and other negative effects on health at much lower levels of exposure

Table E-13: Lead Cases by Level of Blood Lead, Lead Surveillance System, 2004-2005

Blood lead level*	2004	2005	Percent
10-24	298	383	83%
25-39	35	66	14%
40-49	3	9	2%
50-59	3	3	1%
>=60	3	2	0%
Total	342	463	100%

*ug/dl of whole blood

Infectious and Other Diseases

Since 1998, bloodborne disease exposures such as needlesticks have not been reported into the ODSS, so this report only includes other infectious diseases. There were 30 reports of infectious diseases in 2005, approximately the same as 2004. Reports included rabies exposures (13 cases), 4 tuberculosis (TB) infections or PPD conversions (a test for tuberculosis infection), and 3 cases of Lyme Disease or tick bites (Table E-14). Infectious diseases occurred mainly in the Service sector (14 cases).

Table E-14: Infectious and Other Occupational Diseases by Type, ODSS, 2005

Illness	Cases
Rabies	13
TB/PPD	4
Lyme disease/ tick bite	3
Other infectious	10
Headache/dizzy	18
Allergic	16
Hearing loss	10
Heat/cold	8
Heart	4
Chemical exposure	4
Stress	3
Other	7
Total	100

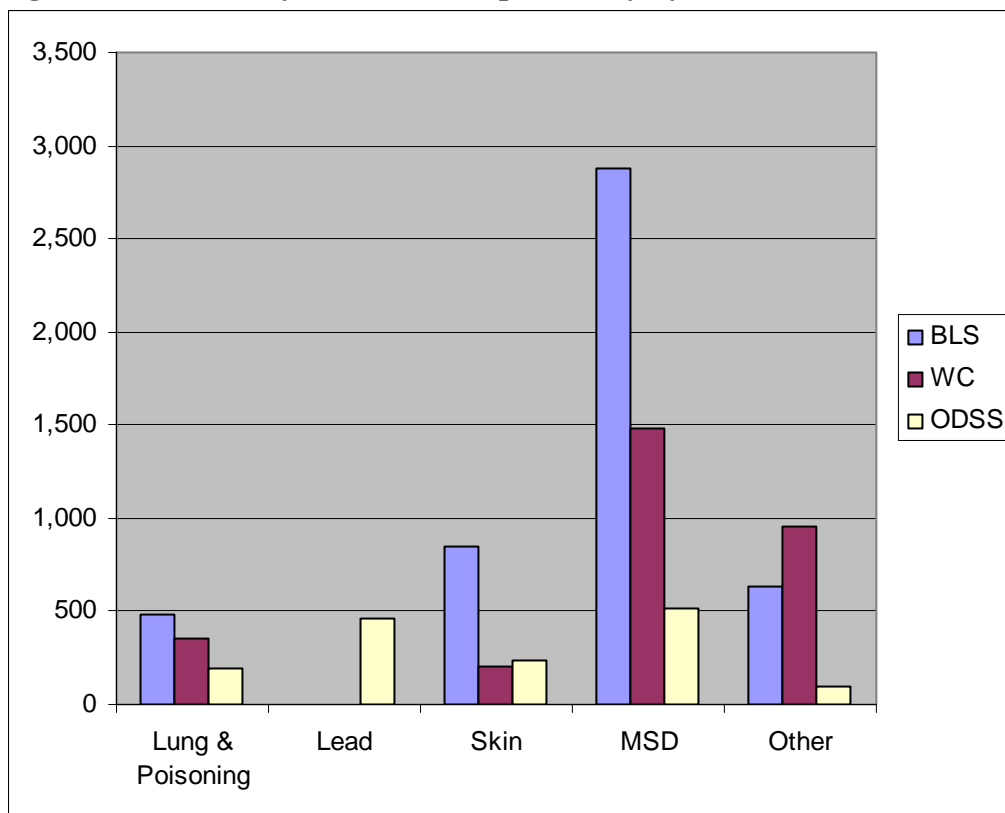
There were 70 “Other” occupational diseases reported, almost a doubling over 2004 after an 80% increase last year. There were 18 cases of headaches or dizziness, 16 allergic reactions to food or other sources, 10 cases of hearing loss reported, 8 cases of heat or cold related conditions, 4 cases of heart or hypertension, 4 chemical exposures, 3 cases of mental stress. One of the “other” cases was a report of bladder cancer from acrylonitrile exposure.

“Other” conditions occurred primarily in the Education and Health sector (21 cases), Government (18) and Manufacturing (13 cases).

F. Summary of Diseases

Figure F-1 shows the totals by disease category for 2005 for the three reporting systems of the Bureau of Labor Statistics/Conn-OSHA (BLS), Workers' Compensation (WC), and the Occupational Disease Surveillance System (ODSS, physician reports). Categories have been combined to make comparisons as close as possible; however, differences in the three systems' definitions make comparisons incomplete. For example, Workers' Compensation only requires reporting for lost-time or restricted duty cases, while the other two reporting systems require all occupational illnesses to be reported. According to the Department of Public Health, although all physicians are legally required to report occupational disease, only a small minority does report. Lead reports from the laboratory reporting system are presented separately, since there are very few lead reports in any of the other systems. The BLS/Conn-OSHA system has discontinued collecting "repetitive trauma" as a category beginning in 2002, so MSD has been estimated based on the proportion of "other illness" in the 2001 dataset, which was 82%. Appendix 1 details differences in the data systems.

Figure F-1: Summary of Diseases Reported, By System, 2005



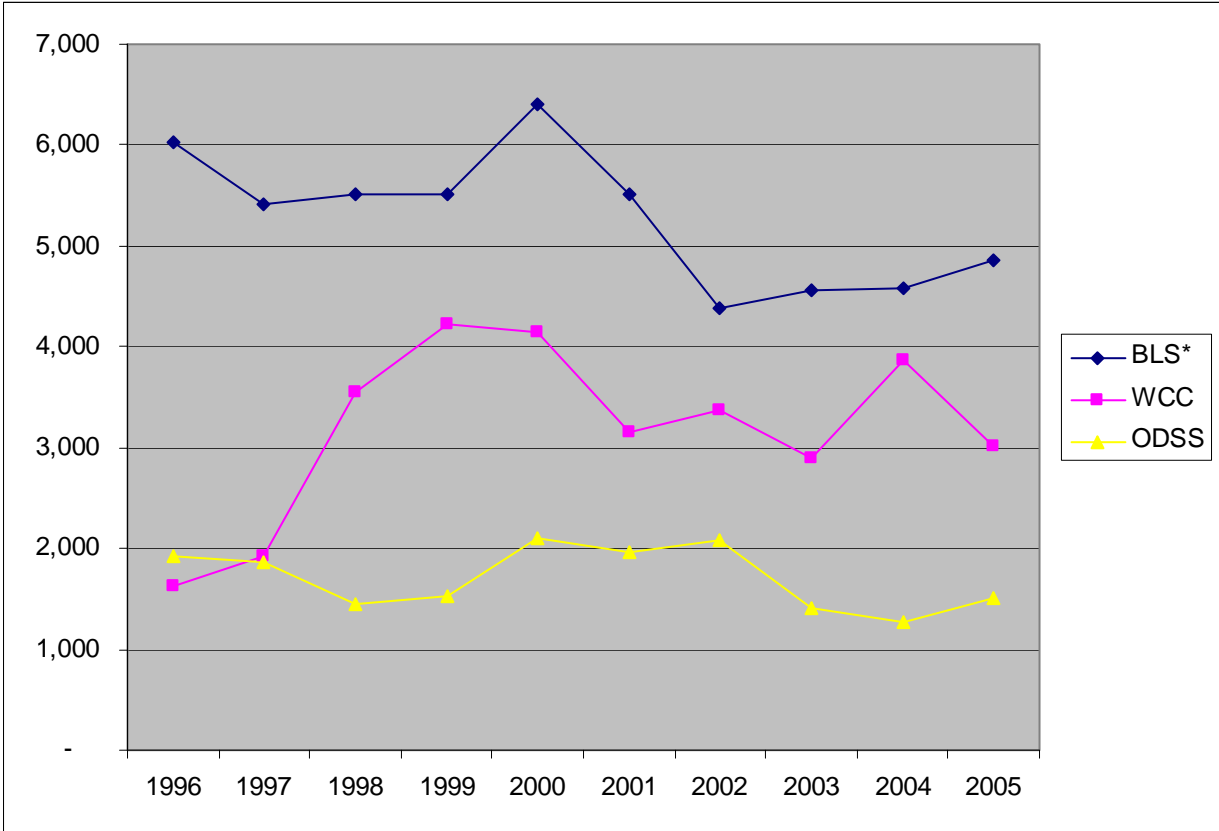
Notes: BLS=Bureau of Labor Statistics/ConnOSHA survey; WC=Workers' Compensation First Report of Injury Database; ODSS= Physicians reports from the Occupational Disease Surveillance System. MSD for the BLS database was estimated using prior proportions from "other".

The BLS/Conn-OSHA database showed the highest number of cases, with 4,851 cases reported, followed by the Workers' Compensation database with 3,008 cases, and the Physicians' reporting database with 1,506 cases, an ordering that holds for most of the conditions.

Overall, BLS reports increased 6% from 2004, while Workers' Compensation reports declined by 22% sharply and ODSS increased 19%. Longer term trends are complex, with BLS trends generally

declining until 2002, with slight increases since, Workers' Compensation showing an early increase, then fluctuated between 3,000 and 4,000 since (it should be noted that the workers' compensation database appeared incomplete in 2003).

Figure F-2 Ten-year trend in Occupational Disease Reports, by Reporting System



Notes: BLS= Bureau of Labor Statistics/Conn-OSHA survey; WCC= Workers' Compensation First Report of Injury; ODSS= Occupational Disease Surveillance System (physician reports).
 *Note: BLS figures in 2002 not comparable to prior years due to changes in data collection. WCC data may not be complete for 2003.

G. Appendix: Databases and Methods

Determining the incidence of occupational illness in Connecticut is difficult. The problem is two-fold: 1) occupationally-related illness is not consistently recognized as work-related; and, 2) the cases reported to either the Department of Labor and/or the occupational health surveillance division of the Department of Public Health are not complete. Consequently, this assessment of occupational disease reviews a number of sources of information: the Workers' Compensation Commission's First Report of Injury database, the Bureau of Labor Statistics/Connecticut Occupational Safety and Health Administration Survey of Occupational Injuries and Illnesses, the Connecticut Occupational Disease Surveillance Program, and the Connecticut Adult Blood Level Epidemiology Surveillance Program. The Workers' Compensation and Physicians' Report databases were provided in electronic form from the Workers' Compensation Commission and from the Department of Public Health. The BLS/Conn-OSHA survey data was provided in table form from the Connecticut Department of Labor.

Assumptions and Conventions

The Workers' Compensation Commission's First Reports of Injury database and the Connecticut Occupational Disease Surveillance System (referred to as Physicians' Reports) were reviewed in depth. A rationale for the data review was developed to differentiate occupational disease from injuries and to classify the workplace reports by nature and cause of the illness. Each entry was reviewed for internal consistency and reasonableness. Specifically, the process employed the following steps:

- 1) **Clear acute injuries were eliminated** (approximately 90% of the Workers' Compensation database, and 30% of the Physicians Reports). In assessing the Workers' Compensation First Reports of Injury, a line by line review of injury descriptions, nature descriptions and codes, listed causes, and part of body were used to determine whether an injury or illness was described. The determination relied most heavily on the injury description and then on the other data fields in the order listed above.

The Physicians' Reports are organized differently. Numerical "Nature of Injury or Illness" codes from the Bureau of Labor Statistics Occupational Injury and Illness Classification System (ANSI Z16.2-1995, American National Standard for Information Management for Occupational Safety and Health) were used as the primary indicator to evaluate the records. Cause, certainty, diagnosis, ICD codes, suspected agent and symptom fields were also reviewed in determining illness or injury. Categories that were eliminated included all burns, eye problems such as conjunctivitis or chemical exposures, lower back problems (including sciatica), hernias, infected wounds or burns, insect and animal bites (with the exception of tick bites because of the Lyme Disease concern), and electrical shocks.

- 2) **Validity of remaining records was determined.** Records were reviewed to be sure that the coding of types of disease was consistent with other information in the record. In addition, diseases were categorized by type of disease. References used include Occupational Health, Recognizing and Preventing Work-Related Disease, Fourth Edition; Levy, Barry S. and Wegman, David H.; Little, Brown and Company; 2000 and Chemical Hazards of the Workplace; Proctor, Nick H. and Hughes, James P.; J.P. Lippincott Company; 1978. Physicians at the University of Connecticut Health Center's Division of Occupational Medicine reviewed specific data records where there were questions about diagnoses..

- 3) **Fields were either revised or added to the databases:** *Illness Type* and *Nature of Illness*. The *Nature of Illness* was based on the information in the databases, research, and general information about the illnesses. Then each entry was categorized by *Illness Type*. The specific nature categories were grouped into broader categories to support graphic representation. For the Workers' Compensation database, the description of injury was used as the key description of the illness if it disagreed with the coding for other variables.
- 4) **Employers were coded for industry** utilizing a comprehensive list of Connecticut employers from the CT Department of Labor. Prior to 2003, this coding utilized the SIC (Standard Industry Classification), but beginning in 2003 this was changed to the NAICS (North American Industry Classification System) for the BLS and workers' compensation data in response to the national change to that system for BLS data. Rates were calculated using employment figures from the Occupational Safety and Health Statistics Division of the CT Labor Dept.
- 5) **Data was cleaned, tabulated and put into presentation form** using SPSS for Windows, Microsoft Access, Excel, and Word software.
- 6) **The report is reviewed** by the Connecticut Workers' Compensation Commission prior to publication.

Appendix H: Occupational Disease Detail by Type and Year
Table H-1: Cases of Occupational Disease, by Type, Bureau of Labor
Statistics/Conn-OSHA, 1979-2005

	Employ.*	All Ill	Skin	MSD	Lung-dust	Respir.	Poison	Physical	Other
1979	1,358	3,322	1,716	471	25	317	175	250	368
1980	1,394	3,066	1,586	513	88	214	66	199	400
1981	1,409	3,214	1,509	701	38	290	89	192	395
1982	1,400	2,549	1,130	580	31	223	31	216	323
1983	1,419	2,930	1,236	665	20	154	152	176	519
1984	1,490	2,735	1,109	665	24	273	65	162	432
1985	1,528	2,809	928	727	44	233	51	130	693
1986	1,567	2,719	808	761	39	274	65	235	538
1987	1,607	4,643	1,352	1,430	31	300	62	704	754
1988	1,637	4,364	1,257	405	35	332	56	405	733
1989	1,634	5,844	1,248	2,629	57	277	74	468	1,087
1990	1,593	5,307	1,032	2,535	93	457	54	496	641
1991	1,518	6,094	946	3,454	62	422	113	501	591
1992	1,483	6,458	1,084	3,852	37	471	53	349	612
1993	1,487	8369	965	5526	52	512	166	346	802
1994	1,502	7,319	957	4,482	74	410	97	313	986
1995	1,520	6,787	884	4,220	80	323	35	349	896
1996	1,538	6,021	827	3,711	40	418	34	235	756
1997	1,570	5,419	620	3,335	21	287	70	150	936
1998	1,597	5,510	989	3,398	10	459	45	92	517
1999	1,630	5,513	793	3,306	20	386	71	265	671
2000	1,653	6,396	897	3,827	65	438	29	137	1,003
2001	1,572	5,514	916	3,220	10	630	29	118	591
	Employ.*	All Ill	Skin			Respir.	Poison		Other
2002	1,602	4,387	831			320	78		3,159
2003	1,605	4,559	903			490	32		3,132
	Employ.*	All Ill	Skin			Respir.	Poison	Hearing	Other
2004	1,603	4,572	832			354	35	466	2,886
2005	1,614	4,850	848			480	8	381	3,134

Source: BLS/Conn-OSHA. Data collection methods and categories changed in 2002, and are not comparable to prior years.
Employment in thousands

Table H-2: Rate per 10,000 Workers of Occupational Disease, by Type, Bureau of Labor Statistics/Conn-OSHA, 1979-2005

Year	Employed	Skin	MSD	Resp/Lung	Poisoning	Other
1979	1,358,000	12.6	3.5	2.5	1.3	8.2
1980	1,394,000	11.4	3.7	2.2	0.5	8.6
1981	1,409,000	10.7	5	2.3	0.6	9.4
1982	1,400,000	8.1	4.1	1.8	0.2	8.2
1983	1,419,000	8.7	4.7	1.2	1.1	9.7
1984	1,490,000	7.4	4.5	2	0.4	8.6
1985	1,528,000	6.1	4.8	1.8	0.3	10.4
1986	1,567,000	5.2	4.9	2	0.4	10.0
1987	1,607,000	8.4	8.9	2.1	0.4	18.2
1988	1,637,000	7.7	2.5	2.2	0.3	9.6
1989	1,634,000	7.6	16.1	2	0.5	26.0
1990	1,593,000	6.5	15.9	3.5	0.3	23.6
1991	1,518,000	6.2	22.8	3.2	0.7	30.4
1992	1,483,000	7.3	26	3.4	0.4	32.7
1993	1,487,000	6.5	37.2	3.8	1.1	45.2
1994	1,501,800	6.4	29.8	3.2	0.6	39.0
1995	1,520,000	5.8	27.8	2.7	0.2	36.5
1996	1,538,000	5.4	24.1	3	0.2	30.8
1997	1,570,500	3.9	21.2	2	0.4	28.3
1998	1,596,900	6.2	21.3	2.9	0.3	25.2
1999	1,630,100	4.9	20.3	2.5	0.4	26.1
2000	1,653,000	5.4	23.2	3	0.2	30.4
2001	1,571,000	5.8	20.5	4.1	0.2	25.1
2002*	1,602,000	5.2	*	2	0.5	19.7
2003	1,605,000	5.6	*	3.1	0.2	19.5
2004	1,603,100	5.2	*	2.2	0.2	20.9
2005	1,614,100	5.3	*	3.0	0.0	21.8

Source: BLS/Conn-OSHA

*Data collection methods and categories changed in 2002, and are not comparable to prior years.

“Other” includes the pre-2002 categories of MSD, Physical, Lung-dust, and Other.

I: Internet Resources for Job Safety and Health

Compiled by Tim Morse, Ph.D., at the ErgoCenter at the University of Connecticut Health Center, tmorse@nso.uhc.edu, 860-679-4720. Please send suggestions for additions.

General Health and Safety Sites

One of the best sources of information for job health and safety on the internet is the **OSHA (Occupational Safety and Health Administration)** homepage, which includes an ergonomics homepage, a searchable index of standards, and a listing of health and safety sites on the internet.

<http://www.osha.gov>

To look up **OSHA citations** by company or industry:

<http://www.osha.gov/cgi-bin/est/est1>

NIOSH (the National Institute for Occupational Safety and Health) is another good general source.

<http://www.cdc.gov/niosh/homepage.html>

EPA has a number of sites relevant to occupational health on indoor air quality, asbestos, and other topics. www.epa.gov <http://www.epa.gov/iaq/homes/index.html>

The **North Carolina Occupational Safety and Health Education and Research Center** is the new home for the occupational health listserve (formerly based at Duke), with a good set of technical links to other occupational health resources.

<http://www.occhealthnews.net>

The **Canadian Centre for Occupational Health and Safety** has hundreds of resources on their health and safety internet resource list. Start at their home page, then choose Resources (on the top bar), then Internet Directory. <http://www.ccohs.ca>

New Jersey Health Dept. has excellent **chemical hazard factsheets** that are free, independently researched, and clearly written (many in Spanish) on hundreds of substances.

<http://web.doh.state.nj.us/rtkhsfs/indexfs.aspx>

Vermont safety information resources has a database of **material safety data sheets (MSDS)** from a large number of chemical companies. <http://www.siri.org>

Several safety organizations have useful websites:

<http://www.nsc.org>

The National Safety Council

www.aiha.org

The American Industrial Hygiene Association

www.asse.org

American Society of Safety Engineers

www.nfpa.org

National Fire Protection Assoc.

www.safetycentral.org

International Safety Equipment Association

For a labor perspective, the **national AFL-CIO** includes a health and safety page.

<http://www.aflcio.org/issues/safety>, and **NYCOSH** (New York Council for Occupational Safety and Health) covers a lot of news and has a listserv. <http://www.nycosh.org>

The **Connecticut Business and Industry Association** has a health and safety page that helps businesses understand what OSHA laws apply to them, and provides information on upcoming conferences and events. <http://www.cbia.com/hr/SafetyAndHealth>

The **Environmental Defense Fund** has a scorecard page with information about the health effects of chemical emissions from 17,000 industrial facilities and the testing of chemicals, with maps and interactive databases. <http://www.scorecard.org/>

The Cal-OSHA Reporter carries current stories on job health and safety at <http://www.cal-osh.com>. There are at least a couple of **blogs that carry job health and safety news and commentary**. These include <http://weeklytoll.blogspot.com> which includes a listing of those who have been killed on the job in the past week, the Pump Handle at <http://thepumphandle.wordpress.com/confined-space-tph> which continues the legacy of Jordan Barab's blog, and <http://workerscompinsider.com> which covers workers' compensation issues.

State of Connecticut Resources

The **Connecticut Workers' Compensation Commission** has an excellent website, including information on the locations of offices, a searchable version of the workers' compensation statutes, new decisions, and other information. <http://wcc.state.ct.us>

The **ConneCT** website allows access to all state agencies: <http://www.state.ct.us>

The **State Department of Public Health** includes a site for the occupational health program, including versions of the occupational lung disease newsletter, factsheets, and other information. <http://www.dph.state.ct.us/BRS/EOHA/HPPEOH.html>

The **Connecticut Labor Department** includes an occupational health services site, which includes information on their free consultation program and a great set of links to other health and safety sites. <http://www.ctdol.state.ct.us/osha/osha.htm>

The Connecticut General Assembly website lets you search for any bill being considered, or get information about relevant committees such as Labor and Public Employees or Public Health. <http://www.cga.ct.gov> You can track national bills on the National Library of Medicine site known as Thomas <http://thomas.loc.gov>

You can search the medical literature at PubMed at www.pubmed.gov or more general academic searches <http://scholar.google.com/schhp?tab=ws> through Google Scholar

UConn Health Center's Occupational and Environmental Health Center has information and links on job health and safety <http://www.oehc.uhc.edu> and has a center on Healthy Workplaces with UMass Lowell at <http://www.uml.edu/stage/centers/cph%2Dnew>

Ergonomic Sites and Links

ErgoCenter at UConn Health Center at <http://www.oehc.uhc.edu/ergo>

Ergoweb has a lot of good factsheets, documents, and news. <http://www.ergoweb.com>

Tom Bernard's website at **University of South Florida** has many of the standards and excellent free electronic ergonomic analysis tools such as the NIOSH lifting equation at <http://personal.health.usf.edu/tbernard/ergotools/index.html>. **Tom Armstrong** at the **University of Michigan** runs one of the most respected university training programs for ergonomics, and at <http://www-personal.umich.edu/~tja> has extensive information, tools, and lectures. **Cornell University's Alan Hedge** has an active ergonomics program, with reports posted on graduate student projects and evaluation of ergonomic products at <http://ergo.human.cornell.edu>. **The University of Virginia** has ergonomics training and resources at <http://keats.admin.virginia.edu/ergo/home.html>

A download of an interesting ergonomics software program developed by Battelle Labs for the Dept. of Energy called **ErgoEaser** is available for free. The program lets you input measurements of workstations and operators to help analyze computer workstations and lifting.

<http://hss.energy.gov/ergoeaser/download.html>

Human Factors and Ergonomics Society is the main professional association in ergonomics.

<http://www.hfes.org>

CTD News Monthly Newsletter homepage. <http://www.ctdnews.com>

User and injured workers groups include lots of links and info from injured workers at the **Typing Injury FAQ** at <http://www.tifaq.com>, **Occupational Overuse Syndrome/RSI** resources <http://www.comp.vuw.ac.nz/General/OOS>, and **RSI/UK** Information about Repetitive Stress Injuries (RSI) originating from the UK, with information gathered from sources around the globe <http://www.rsi-uk.org.uk>. The **Job Stress Network** web page is dedicated to increasing communication among researchers and others interested in job stress and its impact on health. <http://www.workhealth.org>

Usernomics Ergonomics is a commercial site around disability and usability issues.

<http://www.usernomics.com> **IBM's** website on computer ergonomics is at

<http://www.pc.ibm.com/ww/healthycomputing/index.html>, **Medical Multimedia Group** has patient education materials with good graphics and explanations. <http://www.medicalmultimedigroup.com>

J: Who's Who: Resources in Connecticut on Job Safety and Health

Academic Programs and Courses

Central Connecticut State University, School of Technology

Undergraduate program in environmental and occupational safety.

Chairman: George Ku, Ed.D.

Address: Copernicus Hall, CCSU, 1615 Stanley Rd., New Britain, CT 06050

Phone: (860) 832-1852

Fax: (860) 832-1806

e-mail: Kug@ccsu.edu

Web: http://www.technology.ccsu.edu/programs/information/mcm_ocs_index.html

University of Connecticut Health Center, Department of Community Medicine, MPH Program

Masters in Public Health program with ergonomic/occupational health certificate. A Ph.D. program is in development.

Director: David Gregorio, Ph.D.

Address: Farmington, CT 06030-6325

Phone: (860) 679-5480

Fax: (860) 679-5463

e-mail: mph@nso.uchc.edu

Web: http://publichealth.uconn.edu/acprgms_mph_overview.php

OSHA

ConnOSHA: ConnOSHA is a state agency that inspects in the public sector, and does consultations in the private sector.

Director: Richard Palo

Address: Labor Dept., 38 Wolcott Hill Rd., Wethersfield, CT 06109

Phone: (860) 232-6990

Fax: (860) 263-6940

e-mail: Richard.Palo@OSHA.gov

Web: <http://www.ctdol.state.ct.us/osha/osha.htm>

Publications: ConnOSHA Quarterly

OSHA (Occupational Safety and Health Administration): Federal OSHA inspects workplaces in the private sector for violations of standards, and also has information and pamphlets.

OSHA Bridgeport Office (Fairfield, New Haven, and Middlesex counties).

Director: Robert W. Kowalski

Address: 1057 Broad Street, 4th Floor
Bridgeport, Connecticut 06604

Phone: (203) 579-5581; National Hotline after hours, etc.: (800) 321-OSHA

Fax: (203) 579-5516

Web: www.osha.gov (national)

OSHA Hartford Office

Director: Bill Freeman

Address: 450 Main St., Room 613, Hartford, CT 06103

Phone: (860) 240-3152; National Hotline after hours, etc.: (800) 321-OSHA

Fax: (860) 240-3155

Academic Occupational Health Clinics

University of Connecticut Occupational and Environmental Health Center

Clinic Director: Dr. John Meyer

Address: UConn Health Center, 263 Farmington Ave., Dowling North, Farmington, CT 06030-6210

Phone: (860) 679-4947

Fax: (860) 679-1349

e-mail: meyer@uchc.edu

Web: www.oehc.uhc.edu

Yale Occupational and Environmental Medicine Program

Director: Dr. Mark Cullen

Address: Occupational Medicine, 135 College St., New Haven, CT 06510

Phone: (203) 785-4197 Clinic

(203) 785-5885 Office

Fax: (203) 785-7391

Web: www.info.med.yale.edu/intmed/cardio/occmcd

Occupational Health Clinics

CorpCare Occupational Health Center (ECHN)

Director: Carol Holman

Address: 1075 Tolland Turnpike, Manchester, CT 06040

Phone: 860-647-4796

Fax: (860) 646-3945

Web: <http://www.echn.org/hospitals/corpcare>

Hartford Medical Group—Occupational Health

Director: Kent Stahl

Address: 1260 Silas Deane Highway, Wethersfield, CT 06109

Phone: (860) 571-7253

Fax: (860) 258-3600

e-mail: jfundoc@harthosp.org

Other Offices: 100 Simsbury Road Suite 203, Avon (860) 284-5111; 265 Ellington Rd., East Hartford, (860) 569-8800; 256 North Main Street Manchester (860) 646-8595; 336 North Main Street West Hartford (860) 232-4891; 445 South Main Street, West Hartford (860) 561-7111, 1060 Day Hill Road Windsor (860) 683-8383

Web: <http://www.hartfordmedicalgroup.com/infocenter.asp?appid=3&catid=2&itemid=12&itemname=Occupational+Medicine>

Occupational Health Plus, St. Raphael Hospital

Director: Dr. Peter Amato

Address: 175 Sherman Ave., New Haven, CT 06511

Phone: (203) 789-3721

Fax: (203) 867-5455

e-mail: pamato@srhs.org

Web: <http://www.srhs.org/occhealth>

Other Offices: 84 North Main Street, Suite 200, Branford (203) 789-5195; 2080 Whitney Ave., Suite 150 Hamden (203) 789-6240

Concentra

Address: 701 Main Street, East Hartford, CT 06108

Medical Director: David Seinstein

Phone: (860) 289-5561

Fax: (860) 291-1895

e-mail: concentra@.com

Web: www.concentra.com

Other Offices: 972 A West Main Street, New Britain (860) 827-0745; 1080 Day Hill Road, Windsor (860) 298-8442; 8 South Commons Rd, Waterbury (203) 759-1229; 333 Kennedy Drive, Torrington (860) 482-4552; 900 Northrup Rd, Wallingford (203) 949-1534; 370 James Street, New Haven (203) 503-0482; 555 Lordship Blvd, Stratford (203) 380-5945

Eastern Rehabilitation Network, Hartford Hospital

Director: Subramani Seegharama

Address: 181 Patricia M Genova Drive, Newington, CT 06111

Phone: (860) 667-5480-Corporate Office

Fax: (860) 667-8416

e-mail: mail@easternrehab.net

Web: www.easternrehab.net

Other Offices: 100 Simsbury Road, Avon (860) 674-0255; 10 North Main Street, Bristol (860) 584-1485; 265 Ellington Road, East Hartford (860) 291-2789; 2928 Main Street Glastonbury (860) 657-4723; 18 East Granby Road Granby (860) 653-2301; 85 Seymour Street, Suite 604 Hartford (860) 545-5130; 252 North Main Street Manchester (860) 643-3562; 1064 East Main Street Meriden (860) 235-9622; 445 South Main Street West Hartford (860) 521-8800; 334 North Main Street, West Hartford 236-7771 Blue Back Square, 65 Memorial Drive, West Hartford; 1260 Silas Deane Highway Wethersfield (860) 529-3179; 1060 Day Hill Road Windsor (860) 688-0236

Griffin Hospital Occupational Medicine

Address: 100 Commerce Drive. Shelton, CT 06484

Director: Dave Maffei

Phone: (203) 944-3718

Fax: (203) 929-3068

e-mail: dmaffei@griffinhealth.org

Web: <http://www.griffinhealth.org/PatientVisitor/MedicineCenter/>

Middlesex Hospital Occupational Med.

Director: Thomas J. Danyliw, M.D.

Address: 534 Saybrook Rd., Middletown, CT 06457

Phone: (860) 358-2750

Fax: (860) 348-2757

Web: <http://www.midhosp.org/go/midOccupationalMedicine>

Other Office: 192 Westbrook Road, Essex (860) 358-3840

Johnson Occupational Medicine

Director: Michael Erdil

Coordinator: Kathleen Heim

Address: 3 Weymouth Rd. Enfield, CT 06083-2252

Phone: (860) 763-7668

Fax: (860) 763-7676
e-mail: jomc@jmhosp.org
Web: <http://www.johnsonhealthnetwork.com/jomc.htm>

Lawrence and Memorial Occupational Health Center (Pequot Health Center)

Medical Director: Geraldine Ruffa
Contact: Ruth Moreau
Address: 52 Hazlenut Hill Rd., Groton, CT 06340
Phone: (860) 446-8265 x 7074
Fax: (860) 448-6961
Email: rmoreau@lmhosp.org
Web: http://www.lmhospital.org/patient_services/occupational.html

MedWorks

Contact: Mary Lou Oshana
Address: 975 Farmington Ave. Bristol, CT 06010
Phone: 860-589-0114
Fax: 860-589-1936
e-mail: moshana@brishosp.org
Web: http://www.bristolhospital.org/services_medworks.htm
Other Office: 375 East Cedar St., Newington (860) 667-4418

Connecticut Occupational Medicine Partners, St. Francis Hospital and Medical Center

Contact: Elaine Durato
Phone: (860) 714-9434
Fax: (860) 714-8068
e-mail: edurato@stfranciscare.org
Web: <http://www.stfranciscare.org/body.cfm?id=669&action=detail&ref=33>
Offices: Gengras Building, Suite 4302, 114 Woodland Street Hartford: 860-714-4270;
100 Deerfield Road, Windsor, 860-714-9444; 115 Spencer Street, Winsted, 860-738-5808

St. Mary's Hospital Occ. Health Center

Medical Director: Erica Martinucci
Contact: Renee Young
Address: 1320 West Main St., Building 1, Waterbury, CT 06706
Phone: 203 709-4580 or (203) 709-3740 (appointments)
Fax: (203) 709-3741
e-mail: ryoung@stmh.org
Web: http://www.stmh.org/patient_services/occupational_health.html

Organizations

American Lung Association, Connecticut

A non-profit association geared towards preventing lung disease, including occupational lung disease.

CEO: Jeff Seyler

Address: 45 Ash St., East Hartford, CT 06108

Phone: (860) 289-5401, (800) 536-4872

Fax: (860) 289-5405

e-mail: alaofct@aol.com

Web: <http://www.alact.org>

Connecticut Safety Council/Safety Roundtable

Associated with the Connecticut Business and Industry Association, the Council offers seminars, training courses, consulting, and policy discussions on safety and regulations.

Contact: Cindy Panioto

Address: 350 Church St. Hartford, CT 06103-1126

Phone: (860) 244-1900

Fax: (860) 278-8562

e-mail: paniotoc@cbia.com

Web: <http://www.cbia.com/hr/SafetyAndHealth>

ConnectiCOSH (The Connecticut Council for Occupational Safety and Health)

CTCOSH is a union-based non-profit organization for education and political action on job safety and health. They have conferences, fact sheets, and speakers.

Director: Mike Fitts

Address: 683 No. Mountain Rd, Newington, CT 06111

Phone: (860) 953-COSH

Fax: (860) 953-1038

e-mail: connecticosh@snet.net

Ergonomic Technology Center (ErgoCenter)

This is a center for prevention of repetitive strain injuries based at UConn Health Center, which does training, research, consulting, and clinical care.

Director: Martin Cherniack, MD, MPH

Address: DOEM, UCHC, Farmington, CT 06030-6210

Phone: (860) 679-4916

Fax: (860) 679-1349

e-mail: tmorse@nso.uchc.edu

Web: <http://www.oehc.uchc.edu/ergo>

Professional Organizations

American Industrial Hygiene Association (AIHA), Connecticut River Valley Section

A professional association for industrial hygienists.

Web: <http://www.aihacrv.org>

President 2007: Patty Heyl, CIH, CSP, CHMM

Purdue Pharma Technologies, Inc., One Stamford Forum, 201 Tresser Boulevard, Stamford, CT 06901: (203) 588-4066; Fax # (203) 588-6300; patty.hey@pharma.com

President-Elect 2008: Howard J. Cohen, PhD, CIH

University of New Haven, 300 Boston Post Road, West Haven, CT 06511, (203) 932-7238
Fax # (203) 931-6054; hcohen@newhaven.edu

American Society of Safety Engineers (ASSE): A non-profit association for enhancing the competence and knowledge of the safety profession.

Connecticut Valley Chapter (Northern CT)

Address: Box 106, 1131-0 Tolland Turnpike, Manchester, CT 06040

President: Denise Dudek; dudek@cyapco.com

President-elect: Joe Bongiovanni; joseph.bongiovanni@acadiaw.com

Communications Chair: David Gelpke, CSP

Phone: (203) 639-2440

e-mail: dgelpke@canberra.com

Web: <http://ctvalley.asse.org>

Nutmeg Chapter (Southern CT)

Dick Pfeiffer, 203-271-2690 or safety@cyberbury.net

Web: <http://nutmeg.asse.org/index.php>

President: Linda Moquet; 203-298-9161; lmoquet@optonline.net

ASSE Student Section (CCSU)

Contact: Dr. George Ku

Phone: (860) 832-1852

Address: 1615 Stanley St., P. O. Box 4010, New Britain, CT 06050-4010

e-mail: kug@ccsu.edu

Web: <http://clubs.ccsu.edu/asse>

Connecticut Air & Waste Management Association

Forum on environmental/waste issues.

Chairman: Douglas Murray

Phone: (860) 298-6240

e-mail: dmurray@trcsolutions.com

Web: http://www.awma-nes.org/connecticut_chapter.htm

Connecticut Trial Lawyers Association, Workers' Compensation Committee

An association of attorneys specializing in workers' compensation, mostly for claimants.

Chairman: Robert Sheldon, Nathan J. Shafner, Co-Chairs

Address: 100 Wells St., Suite 2H, Hartford, CT 06103

Phone: 860-522-4345

Fax: 860-522-1027

Web: www.cttriallawyers.org

CT Bar Association, Workers' Compensation Section

This is a professional association of attorneys who concentrating in workers' compensation.

Chair: David Morrissey

Phone: (203) 723-6691

e-mail: davidm.law@snet.net

Web: <http://www1.ctbar.org/sectionsandcommittees/sections/WorkersCompensation>

Connecticut Safety Society: A professional association for safety inspectors

President: Tom Hozebin

Contact: Thomas Schinkel, 390 Brook Street, Bristol, CT 06010

Address: 574 N. Elm Street, Wallingford, CT. 06492

Phone: (203)-215-8715

e-mail: pres@ctsafety.org

Web: <http://www.ctsafety.org>

Occupational and Environmental Medical Association of CT (OEMAC)- The association for occupational medicine doctors, including many of the physicians working for industry.

Executive Director: Nancy L. Sullivan

President: Connie Walker

e-mail: 76032.660@compuserve.com

Web: www.acoem.org

Occupational Health Nurses Association: The association of occupational health nurses, including most of the nurses working in industry.

State President: Eileen Holihan

email: eholihan@sikorsky.com

Hartford: Joyanne Durham, joy.durham@hs.utc.com

Web: www.aaohn.org

State Agencies

Department of Public Health, Occupational Health Unit

Investigates clusters of occupational diseases, with programs for radon, asbestos, AIDS, lead, TB control and infectious diseases also at the DPH.

Director: Tom St. Louis

Address: DPH/ OHP, 410 Capitol Ave, MS #11OSP, Hartford, CT 06134-0308

Phone: 860) 509-7744

Fax: (860) 509-7785

Web: http://www.dph.state.ct.us/EOHA/Occupational_Health.htm

Publication: CT Occupational Health e-News

State Office of Emergency Management and Homeland Security

Commissioner: James "Skip" Thomas

Phone: 860-566-3180

Fax: 860-247-0664

e-mail: Comm.demhs@po.state.ct.us

Web: <http://www.ct.gov/hls/site>

State Emergency Response Commission

Oversees plans for response to chemical accidents and collects chemical information for the public under Community Right to Know.

DEP/ Bureau of Waste Management

Administrator: Mark DeCaprio

Address: 79 Elm St., 4th Floor, Hartford, CT 06106-5127

Phone: (860) 424-3373

Fax: (860) 424-4059

Web: <http://www.ct.gov/serc>

Connecticut Fire Academy, Commission on Fire Prevention & Control

Safety Training & Standards compliance.

Training Director: Adam Piskura

Address: 34 Perimeter Road, Windsor Locks, CT 06096-1069

Phone: 860-627-6363 or toll free 877-5CT-FIRE (only in CT)

Fax: 860-654-1889

e-mail: adam.piskura@po.state.ct.us

Web: www.state.ct.us/cfpc

CT Department of Environmental Protection, Radiation Safety Unit

Director: Edward L. Wilds Jr.

Phone: (860) 424-3029; 860-424-3333 24/7 Emergency

Fax: (860) 424-4065

e-mail: edward.wilds@po.state.ct.us

Web: http://www.ct.gov/dep/cwp/view.asp?a=2713&q=324824&depNav_GID=1639&depNav=

Workers' Compensation Commission

Chairman's Office and Review Board

The Commission oversees Workers' Compensation benefits, and provides educational services on occupational safety and health, safety and health committees. The Commission also provides rehabilitation services for workers injured on the job.

Chairman: John A. Mastropietro

Contact person: Stephanie

Address: 21 Oak St., 4th Floor, Hartford, CT 06106-8011

Phone: (860) 493-1500

Information: (800) 223-WORK

Fax: (860) 247-1361

e-mail: wcc.chairmansoffice@po.state.ct.us

Web: <http://wcc.state.ct.us>

Workers' Compensation District Offices

1. 999 Asylum Ave., Hartford, CT 06105; (860) 566-4154; Fax: (860) 566-6137
2. 55 Main St., Norwich, CT 06360; (860) 823-3900; Fax: (860) 823-1725
3. 700 State St., New Haven, CT 06511; (203) 789-7512; Fax: (203) 789-7168
4. 350 Fairfield Ave., 2nd Floor, Bridgeport, CT 06604; (203) 382-5600; Fax: (203) 335-8760
5. 55 West Main St., Waterbury, CT 06702; (203) 596-4207; Fax: (203) 805-6501
6. 233 Main St., New Britain, CT 06051; (860) 827-7180; Fax: (860) 827-7913
7. 111 High Ridge Rd., Stamford, CT 06905-5111; (203) 325-3881; Fax: (203) 967-7264
8. 90 Court St., Middletown, CT 06457; (860) 344-7453; Fax: (860) 344-7487