

SECTION 1 PRODUCERS

1. Is your operation primarily a farm or a ranch? Farm Ranch Both

2. Please answer the following questions for up to three **primary producers** (individuals) on this operation as of today.

	Principal Producer	Producer 2	Producer 3
a. What is the producer's age?	<input type="text"/> <input type="text"/> Years	<input type="text"/> <input type="text"/> Years	<input type="text"/> <input type="text"/> Years
b. Sex of producer?	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
c. Have you ever served on active duty in the U.S. Armed Forces?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, which branch of service?	<input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marines	<input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marines	<input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marines
Years of military service?	<input type="text"/> <input type="text"/> Years	<input type="text"/> <input type="text"/> Years	<input type="text"/> <input type="text"/> Years
Ever deployed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. At which occupation did the producer spend the majority (50% or more) of his/her worktime in the past 12 months?	<input type="checkbox"/> Farm/ranch work <input type="checkbox"/> Other	<input type="checkbox"/> Farm/ranch work <input type="checkbox"/> Other	<input type="checkbox"/> Farm/ranch work <input type="checkbox"/> Other
e. What percentage of this producer's worktime was spent working on the farm/ranch in the past 12 months? (Mark only one.)	<input type="checkbox"/> 100% <input type="checkbox"/> 75-99% <input type="checkbox"/> 50-74% <input type="checkbox"/> 25-49% <input type="checkbox"/> 0-24%	<input type="checkbox"/> 100% <input type="checkbox"/> 75-99% <input type="checkbox"/> 50-74% <input type="checkbox"/> 25-49% <input type="checkbox"/> 0-24%	<input type="checkbox"/> 100% <input type="checkbox"/> 75-99% <input type="checkbox"/> 50-74% <input type="checkbox"/> 25-49% <input type="checkbox"/> 0-24%

SECTION 2 ACUTE INJURIES TO PRODUCERS

Definitions: "Injury" is the result of a sudden, unexpected, forceful event, which has an external cause, and which results in bodily damage or loss of consciousness. "Farm-related" includes work and leisure activities on this operation, plus commuting, transport, and business trips for this operation.

	Principal Producer	Producer 2	Producer 3
3. How many farm-related injuries occurred to each producer during the past 12 months?	<input type="checkbox"/> None <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three or more	<input type="checkbox"/> None <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three or more	<input type="checkbox"/> None <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three or more

The following questions are about the **most serious injury** to each producer. (If no injuries in past 12 months, skip to Section 3.)

4. Where did this injury occur? (Mark only one.)	<input type="checkbox"/> Home/office <input type="checkbox"/> Farm building <input type="checkbox"/> Farm yard <input type="checkbox"/> Field/pasture <input type="checkbox"/> Road/off-farm	<input type="checkbox"/> Home/office <input type="checkbox"/> Farm building <input type="checkbox"/> Farm yard <input type="checkbox"/> Field/pasture <input type="checkbox"/> Road/off-farm	<input type="checkbox"/> Home/office <input type="checkbox"/> Farm building <input type="checkbox"/> Farm yard <input type="checkbox"/> Field/pasture <input type="checkbox"/> Road/off-farm
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	Principal Producer	Producer 2	Producer 3																																																																								
5. What was the primary object or substance that caused this injury? (Mark only one).	<input type="checkbox"/> Tractor <input type="checkbox"/> ATV <input type="checkbox"/> Machinery <input type="checkbox"/> Truck/other vehicle <input type="checkbox"/> Power tool <input type="checkbox"/> Hand tool <input type="checkbox"/> Building/structure <input type="checkbox"/> Ground/floor/surface <input type="checkbox"/> Livestock <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> Tractor <input type="checkbox"/> ATV <input type="checkbox"/> Machinery <input type="checkbox"/> Truck/other vehicle <input type="checkbox"/> Power tool <input type="checkbox"/> Hand tool <input type="checkbox"/> Building/structure <input type="checkbox"/> Ground/floor/surface <input type="checkbox"/> Livestock <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> Tractor <input type="checkbox"/> ATV <input type="checkbox"/> Machinery <input type="checkbox"/> Truck/other vehicle <input type="checkbox"/> Power tool <input type="checkbox"/> Hand tool <input type="checkbox"/> Building/structure <input type="checkbox"/> Ground/floor/surface <input type="checkbox"/> Livestock <input type="checkbox"/> Other, specify: <input type="text"/>																																																																								
6. What body part was injured? (Mark all that apply.)	<input type="checkbox"/> Eye/head/neck <input type="checkbox"/> Chest/trunk <input type="checkbox"/> Back <input type="checkbox"/> Arm/shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Hand/wrist <input type="checkbox"/> Leg/knee/hip <input type="checkbox"/> Ankle/foot/toe <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> Eye/head/neck <input type="checkbox"/> Chest/trunk <input type="checkbox"/> Back <input type="checkbox"/> Arm/shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Hand/wrist <input type="checkbox"/> Leg/knee/hip <input type="checkbox"/> Ankle/foot/toe <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> Eye/head/neck <input type="checkbox"/> Chest/trunk <input type="checkbox"/> Back <input type="checkbox"/> Arm/shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Hand/wrist <input type="checkbox"/> Leg/knee/hip <input type="checkbox"/> Ankle/foot/toe <input type="checkbox"/> Other, specify: <input type="text"/>																																																																								
7. What professional medical care did this injury require? (Mark all that apply.)	<input type="checkbox"/> None <input type="checkbox"/> Doctor/clinic visit <input type="checkbox"/> Hospitalization	<input type="checkbox"/> None <input type="checkbox"/> Doctor/clinic visit <input type="checkbox"/> Hospitalization	<input type="checkbox"/> None <input type="checkbox"/> Doctor/clinic visit <input type="checkbox"/> Hospitalization																																																																								
8. How much lost farm/ranch work time resulted from this injury? (Mark only one.)	<input type="checkbox"/> No lost time <input type="checkbox"/> Less than 1/2 day <input type="checkbox"/> 1/2 to 1 day <input type="checkbox"/> 2 to 6 days <input type="checkbox"/> 7-29 days <input type="checkbox"/> 30 days or more	<input type="checkbox"/> No lost time <input type="checkbox"/> Less than 1/2 day <input type="checkbox"/> 1/2 to 1 day <input type="checkbox"/> 2 to 6 days <input type="checkbox"/> 7-29 days <input type="checkbox"/> 30 days or more	<input type="checkbox"/> No lost time <input type="checkbox"/> Less than 1/2 day <input type="checkbox"/> 1/2 to 1 day <input type="checkbox"/> 2 to 6 days <input type="checkbox"/> 7-29 days <input type="checkbox"/> 30 days or more																																																																								
9. What were the estimated costs from this injury, including out-of-pocket costs and costs paid by insurance? (Mark '0' if none.)	<table border="1"> <tr><td colspan="6">Out-of-pocket</td></tr> <tr><td>\$</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td colspan="6">Insurance paid</td></tr> <tr><td>\$</td><td></td><td></td><td></td><td></td><td></td></tr> </table>	Out-of-pocket						\$						Insurance paid						\$						<table border="1"> <tr><td colspan="6">Out-of-pocket</td></tr> <tr><td>\$</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td colspan="6">Insurance paid</td></tr> <tr><td>\$</td><td></td><td></td><td></td><td></td><td></td></tr> </table>	Out-of-pocket						\$						Insurance paid						\$						<table border="1"> <tr><td colspan="6">Out-of-pocket</td></tr> <tr><td>\$</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td colspan="6">Insurance paid</td></tr> <tr><td>\$</td><td></td><td></td><td></td><td></td><td></td></tr> </table>	Out-of-pocket						\$						Insurance paid						\$					
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10. Please describe how the injury happened. **Use space at the end of the survey for additional detail if needed.	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																								

SECTION 3

CHILDREN, YOUTH AND FAMILY MEMBERS

Number of persons

How many of them were injured?

11. How many children, youth and adult family members lived on this farm/ranch during the past 12 months? (Including producers listed in previous sections)

(mark '0' if none)

(mark '0' if none)

- a. Children 0 - 9 years of age ----->
- b. Youth 10 - 19 years of age ----->
- c. Adults 20 - 64 years of age ----->
- d. Adults 65 years of age and older ----->

SECTION 4

HIRED WORKERS

Number of persons

How many of them were injured?

12. How many hired farm workers, including paid family members and office workers

(mark '0' if none)

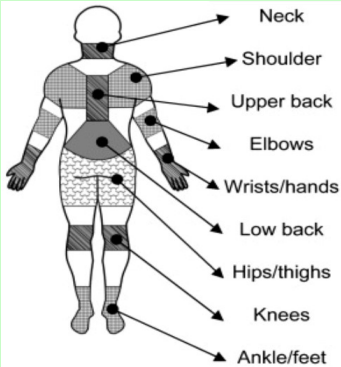
(mark '0' if none)

- a. Worked less than 150 days on this operation during the past 12 months?
- b. Worked 150 days or more on this operation during the past 12 months?

SECTION 5

CHRONIC HEALTH CONDITIONS TO PRODUCERS

	Principal Producer	Producer 2	Producer 3
<p>13. Respiratory diseases: Has the producer ever been diagnosed by a physician with any of the following respiratory conditions? (Mark all that apply.)</p>	<input type="checkbox"/> None <input type="checkbox"/> Chronic obstructive pulmonary dis. (COPD) <input type="checkbox"/> Asthma <input type="checkbox"/> Farmers lung <input type="checkbox"/> Sinus disease (Sinusitis) <input type="checkbox"/> Nasal inflammation, runny nose (Rhinitis) <input type="checkbox"/> Environ. allergies	<input type="checkbox"/> None <input type="checkbox"/> Chronic obstructive pulmonary dis. (COPD) <input type="checkbox"/> Asthma <input type="checkbox"/> Farmers lung <input type="checkbox"/> Sinus disease (Sinusitis) <input type="checkbox"/> Nasal inflammation, runny nose (Rhinitis) <input type="checkbox"/> Environ. allergies	<input type="checkbox"/> None <input type="checkbox"/> Chronic obstructive pulmonary dis. (COPD) <input type="checkbox"/> Asthma <input type="checkbox"/> Farmers lung <input type="checkbox"/> Sinus disease (Sinusitis) <input type="checkbox"/> Nasal inflammation, runny nose (Rhinitis) <input type="checkbox"/> Environ. allergies
<p>14. Hearing loss: Does the producer have hearing loss? (diagnosed or self-assessed) (Mark only one.)</p>	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<p>15. Skin diseases: Has the producer ever been diagnosed by a physician with any of the following skin conditions? (Mark all that apply.)</p>	<input type="checkbox"/> None <input type="checkbox"/> Irritant dermatitis <input type="checkbox"/> Allergic dermatitis <input type="checkbox"/> Skin cancer <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> None <input type="checkbox"/> Irritant dermatitis <input type="checkbox"/> Allergic dermatitis <input type="checkbox"/> Skin cancer <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> None <input type="checkbox"/> Irritant dermatitis <input type="checkbox"/> Allergic dermatitis <input type="checkbox"/> Skin cancer <input type="checkbox"/> Other, specify: <input type="text"/>
<p>16. Work strain symptoms: Did the producer experience extended work periods that resulted in any of the following during the past 12 months? (Mark all that apply.)</p>	<input type="checkbox"/> None <input type="checkbox"/> High stress level <input type="checkbox"/> Sleep deprivation <input type="checkbox"/> Exhaustion/fatigue <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> None <input type="checkbox"/> High stress level <input type="checkbox"/> Sleep deprivation <input type="checkbox"/> Exhaustion/fatigue <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> None <input type="checkbox"/> High stress level <input type="checkbox"/> Sleep deprivation <input type="checkbox"/> Exhaustion/fatigue <input type="checkbox"/> Other, specify: <input type="text"/>

	Principal Producer	Producer 2	Producer 3
<p>17. Musculoskeletal discomfort: Did the producer experience pain or discomfort that affected his/her work in any of the following body areas during the past 12 months? (Mark all that apply.)</p> 	<input type="checkbox"/> None <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper back <input type="checkbox"/> Elbows <input type="checkbox"/> Wrists/hands <input type="checkbox"/> Low back <input type="checkbox"/> Hips/thighs <input type="checkbox"/> Knees <input type="checkbox"/> Ankle/feet	<input type="checkbox"/> None <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper back <input type="checkbox"/> Elbows <input type="checkbox"/> Wrists/hands <input type="checkbox"/> Low back <input type="checkbox"/> Hips/thighs <input type="checkbox"/> Knees <input type="checkbox"/> Ankle/feet	<input type="checkbox"/> None <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper back <input type="checkbox"/> Elbows <input type="checkbox"/> Wrists/hands <input type="checkbox"/> Low back <input type="checkbox"/> Hips/thighs <input type="checkbox"/> Knees <input type="checkbox"/> Ankle/feet

SECTION 6 EXPOSURES TO PRODUCERS

	Principal Producer	Producer 2	Producer 3																		
<p>18. Respiratory exposures: Was the producer exposed to high levels of any of the following air contaminants during the past 12 months? (Mark all that apply.)</p>	<input type="checkbox"/> None <input type="checkbox"/> Grain/feed/hay dust <input type="checkbox"/> Animal confinem. dust <input type="checkbox"/> Field/road dust <input type="checkbox"/> Manure/silage gases <input type="checkbox"/> Anhydrous ammonia <input type="checkbox"/> Fuels/solvents/paints <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> None <input type="checkbox"/> Grain/feed/hay dust <input type="checkbox"/> Animal confinem. dust <input type="checkbox"/> Field/road dust <input type="checkbox"/> Manure/silage gases <input type="checkbox"/> Anhydrous ammonia <input type="checkbox"/> Fuels/solvents/paints <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> None <input type="checkbox"/> Grain/feed/hay dust <input type="checkbox"/> Animal confinem. dust <input type="checkbox"/> Field/road dust <input type="checkbox"/> Manure/silage gases <input type="checkbox"/> Anhydrous ammonia <input type="checkbox"/> Fuels/solvents/paints <input type="checkbox"/> Other, specify: <input type="text"/>																		
<p>19. When exposed to high levels of air contaminants at work, what percent (%) of that time did the producer use proper respiratory protection (incl. N95 dust mask, half mask with dust/gas filters)?</p>	<table border="1"> <tr> <th colspan="3">Amount of Time (%)</th> </tr> <tr> <td style="width: 33.33%;"></td> <td style="width: 33.33%;"></td> <td style="width: 33.33%;"></td> </tr> </table>	Amount of Time (%)						<table border="1"> <tr> <th colspan="3">Amount of Time (%)</th> </tr> <tr> <td style="width: 33.33%;"></td> <td style="width: 33.33%;"></td> <td style="width: 33.33%;"></td> </tr> </table>	Amount of Time (%)						<table border="1"> <tr> <th colspan="3">Amount of Time (%)</th> </tr> <tr> <td style="width: 33.33%;"></td> <td style="width: 33.33%;"></td> <td style="width: 33.33%;"></td> </tr> </table>	Amount of Time (%)					
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<p>20. Noise exposures: Was the producer exposed to high levels of noise from any of the following sources during the past 12 months? (Mark all that apply.)</p>	<input type="checkbox"/> None <input type="checkbox"/> Tractors <input type="checkbox"/> Combines <input type="checkbox"/> Implements <input type="checkbox"/> Power tools <input type="checkbox"/> Animals <input type="checkbox"/> Firearms <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> None <input type="checkbox"/> Tractors <input type="checkbox"/> Combines <input type="checkbox"/> Implements <input type="checkbox"/> Power tools <input type="checkbox"/> Animals <input type="checkbox"/> Firearms <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> None <input type="checkbox"/> Tractors <input type="checkbox"/> Combines <input type="checkbox"/> Implements <input type="checkbox"/> Power tools <input type="checkbox"/> Animals <input type="checkbox"/> Firearms <input type="checkbox"/> Other, specify: <input type="text"/>																		

	Principal Producer	Producer 2	Producer 3																		
21. When exposed to high levels of noise at work, what percent (%) of that time did the producer use proper hearing protection (ear muffs or ear plugs)?	<table border="1"> <tr><td colspan="3">Amount of Time (%)</td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>	Amount of Time (%)						<table border="1"> <tr><td colspan="3">Amount of Time (%)</td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>	Amount of Time (%)						<table border="1"> <tr><td colspan="3">Amount of Time (%)</td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>	Amount of Time (%)					
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22. Skin exposures: Was the producer exposed to any of the following chemicals or animal based allergens while working during the past 12 months? (Mark all that apply.)	<input type="checkbox"/> None <input type="checkbox"/> Pesticides/fertilizers <input type="checkbox"/> Animals/livestock <input type="checkbox"/> Detergents/disinfectants <input type="checkbox"/> Fuels/solvents/paints <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> None <input type="checkbox"/> Pesticides/fertilizers <input type="checkbox"/> Animals/livestock <input type="checkbox"/> Detergents/disinfectants <input type="checkbox"/> Fuels/solvents/paints <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> None <input type="checkbox"/> Pesticides/fertilizers <input type="checkbox"/> Animals/livestock <input type="checkbox"/> Detergents/disinfectants <input type="checkbox"/> Fuels/solvents/paints <input type="checkbox"/> Other, specify: <input type="text"/>																		
23. When exposed to chemicals at work, what percent (%) of that time did the producer use proper personal protection equipment (PPE) (apron, goggles, gloves)?	<table border="1"> <tr><td colspan="3">Amount of Time (%)</td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>	Amount of Time (%)						<table border="1"> <tr><td colspan="3">Amount of Time (%)</td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>	Amount of Time (%)						<table border="1"> <tr><td colspan="3">Amount of Time (%)</td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>	Amount of Time (%)					
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24. Musculoskeletal exposures: Was the producer exposed to any of the following situations at work during the past 12 months? (Mark all that apply.)	<input type="checkbox"/> None <input type="checkbox"/> Forceful exertions <input type="checkbox"/> Repetitive tasks <input type="checkbox"/> Awkward postures <input type="checkbox"/> Frequent manual labor <input type="checkbox"/> Vibration <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> None <input type="checkbox"/> Forceful exertions <input type="checkbox"/> Repetitive tasks <input type="checkbox"/> Awkward postures <input type="checkbox"/> Frequent manual labor <input type="checkbox"/> Vibration <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> None <input type="checkbox"/> Forceful exertions <input type="checkbox"/> Repetitive tasks <input type="checkbox"/> Awkward postures <input type="checkbox"/> Frequent manual labor <input type="checkbox"/> Vibration <input type="checkbox"/> Other, specify: <input type="text"/>																		
25. Was the producer using any of the following preventive techniques to maintain his/her musculoskeletal health during the past 12 months? (Mark all that apply.)	<input type="checkbox"/> None <input type="checkbox"/> Regular breaks <input type="checkbox"/> Stretching <input type="checkbox"/> Exercising <input type="checkbox"/> Good lifting techniques <input type="checkbox"/> Mechanizing tasks <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> None <input type="checkbox"/> Regular breaks <input type="checkbox"/> Stretching <input type="checkbox"/> Exercising <input type="checkbox"/> Good lifting techniques <input type="checkbox"/> Mechanizing tasks <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="checkbox"/> None <input type="checkbox"/> Regular breaks <input type="checkbox"/> Stretching <input type="checkbox"/> Exercising <input type="checkbox"/> Good lifting techniques <input type="checkbox"/> Mechanizing tasks <input type="checkbox"/> Other, specify: <input type="text"/>																		

SECTION 7

26. Respondent:

Date: / / 2023

27. Comments:

THANK YOU FOR COMPLETING THIS SURVEY.

Please review survey results from previous years at: <https://www.unmc.edu/publichealth/cscash/>
This survey is funded by the Centers for Disease Control and Prevention (CDC) award (U54-OH010162) to the Central States Center for Agricultural Safety and Health which is housed at the University of Nebraska Medical Center.