Part I: Quantitative data

| No. | Questions                  | Coding category                                                                 |
|-----|----------------------------|----------------------------------------------------------------------------------|
|     | Part 1. Sociodemographic Characteristics |                                                                                 |
| 101 | Sex?                       | 1. Male                                                                          |
|     |                             | 2. Female                                                                        |
| 102 | Age?                       | ________________ Years                                                             |
| 103 | Marital status?            | 1. Single                                                                        |
|     |                             | 2. Married                                                                       |
|     |                             | 3. Divorced                                                                     |
|     |                             | 4. Separated                                                                    |
|     |                             | 5. Widowed                                                                       |
|     |                             | 999. Others                                                                       |
| 104 | Number of family members?  | --------------------------------------------------------------------------------- |
| 105 | Educational level?         |                                                                                |
| 106 | Your income per month?     | 1. Salary                                                                        |
|     |                             | 999. Other                                                                       |
| 107 | Religion of respondent     | 1. Orthodox                                                                      |
|     |                             | 2. Muslim                                                                       |
|     |                             | 3. Protestant                                                                    |
|     |                             | 999. Others (specify)                                                           |
| 108 | Ethnicity of the respondent|                                                                                |

Part 2. Worker’s Behavior information

| No. | Questions                                         | Coding category                                                                 |
|-----|---------------------------------------------------|----------------------------------------------------------------------------------|
| 201 | Do you drink alcohol?                             | 1. Yes                                                                          |
|     |                                                  | 2. No                                                                            |
| 202 | If yes is your answer for the Q.201. How often do you drink? | 1. Every day                                                                     |
|     |                                                  | 2. Once per week                                                                 |
|     |                                                  | 3. Occasionally                                                                  |
|     |                                                  | 4. Once per month                                                                |
|     |                                                  | 999. Other (specify)                                                            |
| 203 | Do you smoke cigarette or drugs that can be smoked? | 1. Yes                                                                          |
|     |                                                  | 2. No                                                                            |
| Question | Options |
|----------|---------|
| Q.204   | If yes is your answer for the Q.203. How often do you smoke? | 1. Every day  
2. Once per week  
3. Occasionally  
4. Once per month  
999. Other (specify) |
| Q.205   | Do you chew chat? | 1. Yes  
2. No |
| Q.206   | How often do you chew chat? | 1. Every day  
2. Once per week  
3. Occasionally  
4. Once per month  
999. Other (specify) |
| Q.207   | Do you have sleeping disorder/problem? | 1. Yes  
2. No |
| Q.208   | What do you think the reason for sleeping disorder/problem? | 1. Working long hours in this company  
2. Engaging additional duties outside this company  
3. Work burden  
4. Personal issues  
5. Shift irregularity  
999. Other (specify) |

**Part 3. Work related information**

| Question | Options |
|----------|---------|
| Q.301   | Which department are you working in the hotel/job category? | ------------------ |
| Q.302   | Pattern of employment? | 1. I am permanent staff  
2. I am temporary staff |
| Q.303   | How many years have you worked in a hotel? Work experience? | _____________ months/years |
| Q.304   | Service duration on the current position? | _____________ months/years |
| Q.305   | Do you work in shift? | 1. Yes  
2. No |
| Q.306   | Are you happy in your job? | 1. Yes  
2. No |
| Q.307   | Do your work places supervised? | 1. Yes there is supervision  
2. No supervision at all  
3. It is supervised irregularly  
999. Other specify |
| Q.308   | Have you had any occupational safety training in this hotel? | 1. Yes  
2. No |
| Q.309   | When was your last safety training you have taken? | _________________ months/years |
### Part 4. Occupational injury characteristics

|   | Question                                                                 | Options                                                                 |
|---|--------------------------------------------------------------------------|-------------------------------------------------------------------------|
| 401 | Have you encountered any occupational injury while you were on duty/working in the last 12 months? | 1. Yes  
2. No                                                                 |
| 402 | Was the accident in the hotel premises?                                  | 1. Yes, it was in the hotel premises  
2. No, it was not                                                        |
| 403 | Where the injury while you were out of the hotel for work related purpose? | 1. Yes, it was  
2. No, it was not                                                      |
| 404 | What were you doing at the time of injury?                               | -------------------------  
| 405 | In which shift were you working while the accident happened?             | 1. Morning shift  
2. Evening shift  
3. Night shift                                                            |
| 406 | To whom was the accident reported?                                       | 1. To a Supervisor  
2. To a friend  
3. To a work partner  
4. I didn’t report to any one  
999. Others (specify)                                                     |
| 407 | Part of body affected?                                                   | 1. Eye  
2. Head  
3. Chest/shoulders  
4. Back  
5. Abdomen  
6. Arm  
7. Hand-finger  
8. Leg  
9. Foot-toe  
10. Respiratory system  
999 Other                                                                  |
| 408 | Type of injury?                                                          | 1. Lacerations  
2. Abrasion  
3. Puncture/cut  
4. Burn  
5. Fracture  
6. Strain/sprain  
7. Amputation  
8. Foreign body  
9. Poisoning  
10. Contusion  
11. Fall  
12. Electrocution  
13. Others                                                                  |
| Q   | Question                                                                 | Options                                                                 |
|-----|--------------------------------------------------------------------------|------------------------------------------------------------------------|
| 409 | Cause of injury?                                                         | 1. Struck by/against an object                                         |
|     |                                                                          | 2. Machinery                                                            |
|     |                                                                          | 3. Hit by falling object                                                |
|     |                                                                          | 4. Slips/trips/fall                                                    |
|     |                                                                          | 5. Hand tools                                                           |
|     |                                                                          | 6. Chemicals                                                           |
|     |                                                                          | 7. Fire /hot pans/oils                                                 |
|     |                                                                          | 8. Lifting heavy objects                                               |
|     |                                                                          | 9. Electricity                                                         |
|     |                                                                          | 999. Others specify                                                    |
| 410 | Were you hospitalized because the injury?                                | 1. Yes                                                                 |
|     |                                                                          | 2. No                                                                  |
| 411 | For how long did you stay in the hospital/clinic?                        |                                                                       |
|     |                                                                          | ________________ days/months                                            |
| 412 | Had you had any disability because of the injury?                        | 1. Yes                                                                 |
|     |                                                                          | 2. No                                                                  |
| 413 | If Yes is your answer for Q.412 What type of disability had you because of the injury? | 1. Temporary 2. Permanent                                              |
| 414 | Have you been on sick leave                                              | 1. Yes                                                                 |
|     |                                                                          | 2. No                                                                  |
| 415 | Sick leave days given because of the injury?                              |                                                                       |
|     |                                                                          | ___________________________                                             |
| 416 | Have you used Personal protective equipment at the time of injury?        | 1. Yes                                                                 |
|     |                                                                          | 2. No                                                                  |
| 417 | If “yes” is your answer for Q.416, What type of PPE were you using?      | 1. Glove                                                               |
|     |                                                                          | 2. Ear plug                                                            |
|     |                                                                          | 3. Mask                                                                |
|     |                                                                          | 4. Helmet                                                              |
|     |                                                                          | 5. Goggle                                                              |
|     |                                                                          | 6. Face shield                                                         |
|     |                                                                          | 7. Boot                                                                |
|     |                                                                          | 8. apron                                                               |
|     |                                                                          | 999. Other-------                                                      |
|   |   |
|---|---|
| **418** | If “No” is your answer for Q.416 Please mention your reason for not using PPE? |
|   | 1. Absence of protective devices 2. Not comfortable to use / fit 3. Absence of safety & health education 4. It decreases work performance 5. Create health & safety hazards 999. Other, specify |
| **419** | What do you think the reason for the cause of injury? |
|   | --------------------------- |

**Part II: Qualitative data Check List**

|   |   |
|---|---|
| 1 | Total number of employees in the hotel? |
| 2 | What is the hotel safety inspection activity? (Probe) |
| 3 | How do you manage/handle injuries? (Probe) |
| 4 | Is there injury investigation and management system in the hotel? (Probe) |
| 5 | PPE supply and use? (Probe) |
| 6 | Is there safety and health training in the hotel? How frequent? (Probe) |
| 7 | Is there 1st aid training for Employees? How often do you? (Probe) |
| 8 | How many injuries do occur in the last 12 months? (Probe) |
| 9 | How do you explain the severity of injuries happened in this hotel? (Probe) |