Print Form

New York State Department of Labor
Log of Work Related Injuries and Illnesses Form SH-900

Political Subdivision (Employer) ____________________

Establishment Name ____________________

Street Address ____________________

City ____________________ State ______ Zip Code ____________

Calendar Year 20 ____

Page ____ of ____

1. This form is required by the Commissioner of Labor's Rules and Regulations Part 801 (12 NYCRR Part 801) and must be kept in the establishment for five years. Failure to maintain this form can result in the issuance of a Notice of Violation and Order to Comply.
2. You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injures and illnesses that meet any of the specific recording criteria found in 12 NYCRR 801.7 - 801.12 and instructions.
3. Use more than one line for a single case if necessary.
4. This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. Refer to the instructions (SH-901) for types of illness and injuries defined as privacy concern cases.

						Using these categories, check ONLY the most serious result for each case.				Enter No. of Days Injured or Ill Worker Was:		M. Check the Injury Column or Check One Type of Illness					
								Remained at Work									
A.Case No.	B. Employee Name	C. Job Title	D. Date of Injury or Onset of Illness (Mo./day)	E. Where the Event Occurred (e.g., Loading dock, north end)	F. Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g., Second degree burns on right forearm from acetylene torch)	G. Death	H. Days Away From Work	I. Job Transfer or Restriction	J. Other Recordable Cases	K. Away from Work	L. On Job Transfer or restriction	1. Injury	2. Skin Disorder	3. Respiratory Condition	4. Poisoning	5. Hearing Loss	6. All Other Illnesses
					TOTALS												

Additional forms and information: If you require additional forms or information concerning the completion of this form, contact: Department of Labor, Division of Research and Statistics, 75 Varick St., 7th Floor, New York, NY 10013. Telephone (212) 775-3344.

STATE OF NEW YORK
DEPARTMENT OF LABOR

Divison of Safety and Health
Public Employee Safety and Health
State Office Campus
Building 12, Room 158
Albany, NY 12240

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH-900.1

Calendar Year _____

All establishments covered by PART 801 **must** complete this summary annually, even if no occupational injuries or illnesses occurred during the year.

Employees, former employees, and their representatives have the right to review this form. They also have limited access to the Log (SH 900) or its equivalent. See 801.35 and instructions for further details on access provisions for these forms.

1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS	AVERAGE NUMBER OF EMPLOYEES _____
CITY, STATE, ZIP CODE	
INDUSTRY DESCRIPTION (e.g.,village fire department)	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR _____
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS). _____ _____ _____ _____ _____ _____	

Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each category (column labels under each line correspond to the columns on the Log). If a category has no cases, enter "0."

3. NUMBER OF CASES	4. NUMBER OF DAYS	5. INJURIES AND ILLNESS TYPES
DEATHS _____ (Col. G)	AWAY FROM WORK _____ (Col. K)	INJURIES _____ (Col.1)
DAYS AWAY FROM WORK _____ (Col. H)	JOB TRANSFER OR RESTRICTION _____ (Col. L)	SKIN DISORDERS _____ (Col. 2)
JOB TRANSFER OR RESTRICTION _____ (Col. I)		RESPIRATORY CONDITIONS _____ (Col. 3)
OTHER RECORD-ABLE CASES _____ (Col. J.)		POISONINGS _____ (Col. 4)
		HEARING LOSS _____ (Col. 5)
		ALL OTHER ILLNESSES _____ (Col. 6)

6. CERTIFICATION

I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.

SIGNATURE _____ TITLE _____

PRINT NAME _____ DATE _____

CALCULATING EMPLOYMENT INFORMATION (Section 2)

If accurate figures regarding the average number of employees and the total hours worked by your employees are not available, please use the steps below to estimate these numbers.

Average Number of Employees

1. Add the total number of employees paid in all pay periods for the year. Include all full-time, part-time, temporary, seasonal, salaried, and hourly employees. _____ (a)

2. Count the number of pay periods for the year, including pay periods with no employees. _____ (b)

3. Divide the number of employees by the number of pay periods. _____ (a) / _____ (b) _____ (c)

4. Round the answer to the next whole number. Enter this number in the line for "Annual average number of employees" in Item 2 on the front. _____ (d)

Total Hours Worked By All Employees

1. Enter the number of full-time employees in your establishment for the year. _____ (e)

2. Enter the number of work hours for a full-time employee in a year. _____ (f)

3. Multiply (e) by (f) to find the number of full-time hours worked. **x** _____ (g)

4. Add number of overtime hours and number of hours worked by other employees (part-time, temporary, seasonal). **+** _____ (h)

5. Round the answer to the next highest whole number. Enter this number in the lines for "Total Hours Worked by All Employees Last Year" in Item 2 on the front. _____ (i)

NEW YORK STATE - DEPARTMENT OF LABOR
INJURY AND ILLNESS INCIDENT REPORT

FORM SH 900.2

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and PESH develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent.

Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to 12NYCRR Part 801, PESH recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____

Title _____

Phone (____)_____**Date** _____/_____/_____

Employee Information:

1) Full name _____
2) Street _____
City _____ State _____ Zip _____
3) Date of birth _____/_____/_____ 4) Date hired _____/_____/_____
5)

☐ Male ☐ Female

Physician/Health Care Professional Information:

6) Name of physician or other health care professional
_____

7) If treatment was given away from the worksite, where was it given?
_____ _____

Facility _____
Street
City _____ State _____ Zip _____

8) Was employee treated in an emergency room?

☐ Yes ☐ No

9) Was employee hospitalized overnight?
☐ Yes ☐ No

Information about the case:

10) Case number from the *Log* _____
(Transfer the case number from the Log after you record the case.)

11) Date of injury or illness _____/_____/_____

12) Time employee began work _____ ☐AM / ☐ PM

13) Time of event _____ ☐ AM / ☐ PM

☐ Check if time cannot be determined
Event occurred ☐ before ☐ during ☐ after work shift

14) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials", "spraying chlorine from hand sprayer."

15) **What happened?** Tell us how the injury occurred. *Examples*: "When ladder slipped on wet floor, worker fell 20 feet", "Worker was sprayed with chlorine when gasket broke during replacement."

16) **What was the injury or illness?** Tell us the part of the body that was affected; be more specific than "hurt", "pain", or "sore." *Examples*: "strained back", "chemical burn, hand."

17) **What object or substance directly harmed the employee:** *Examples*: "concrete floor", "radial arm saw", "chlorine."

18) **If the employee died, when did death occur?** Date of death _____/_____/_____

ILLNESS CASES ONLY ☐ Check this box if the employee independently and voluntarily requests that his or her name not be entered on the log. If checked, treat as a privacy concern case.