State of New York
Department of Labor
Form SH-900

Log of Work-Related Injuries and Illnesses

Political Subdivision (Employer)____
Establishment Name____
Street Address____
City___________________________ State_______ Zip Code_____________
Region_________________ **District**____________________________ **Empowerment Schools Network**______________________

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 healthcare professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria found in12 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 health purposes. Refer to the instructions (SH-901) for types of illnesses and injuries defined as "privacy concern cases".

Identify the person		***Describe the case***				***Classify the case***													
						Using these four categories, check ONLY the most serious result for each case:				***Enter the number of days the injured or ill worker was:***				***M. Check the "injury" column or choose one type of illness:***					
(A) Case no.	(B) Employee's name	(C) Job title	(D) Date of injury or onset of illness *(month/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)*	***Death***	***Days away***	***Remained at work*** Job transfer or restriction	***Remained at work*** Other record-able cases	Away from work		On Job transfer or restriction		Injury	Skin Disorder	Respiratory Condition	Poisoning	Hearing Loss	All Other Illnesses
						(G)	(H)	(I)	(J)	(K)		(L)		(1)	(2)	(3)	(4)	(5)	(6)
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ADDITIONAL FORMS AND INFORMATION: If you require additional forms or information concerning the completion of this form, contact:
The Office of Occupational Safety and Health at (718) 935-2319 Fax Number (718) 935-4682
SH 900 (11-03)