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

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: NYC-DOHMH / BMIRH	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: ①1826 ARTHUR AVE ②2432 GRAND CONCOURSE	AVERAGE NUMBER OF EMPLOYEES: 9
CITY, STATE, ZIP CODE: BRONX, NY ①10457 ②10458	
INDUSTRY DESCRIPTION (e.g.,village fire department)	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 15,750
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).	

* STAFF OCCUPIED SITE #2 from 1/1/03 - 6/30/03 *

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Haywood Stephney, Sr. TITLE: Site Administrator

PRINT NAME: Haywood Stephney, Sr. DATE: 2/2/04

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Divison of Safety and Health
Public Employee Safety and Health
State Office Campus
Building 12, Room 158
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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH-900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: NYC-DOHMH / BMIRH	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 1727 Amsterdam Ave, 3rd fl.	AVERAGE NUMBER OF EMPLOYEES: 9
CITY, STATE, ZIP CODE: NY, NY 10031	
INDUSTRY DESCRIPTION (e.g.,village fire department)	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 15,750
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)			SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)	AWAY FROM WORK	0 (Col. L)	RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Haywood Stephney TITLE Site Administrator

PRINT NAME HAYWOOD STEPHNEY, JR DATE 2/2/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Manoanca Chest Clinic	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 1309 Fulton Ave Rm 100 1st fl	AVERAGE NUMBER OF EMPLOYEES: 47
CITY, STATE, ZIP CODE: Bronx, NY 10456	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 83,000
INDUSTRY DESCRIPTION (e.g.,village fire department): Clinic	
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Wanda Osborne TITLE PPP/Office Mgr

PRINT NAME Wanda Osborne DATE 2/12/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: Operations - Richmond Health Ctr.

STREET ADDRESS: 51 Stuyvesant Place Rm 227

CITY, STATE, ZIP CODE: Staten Island, NY 1030[illegible]

INDUSTRY DESCRIPTION (e.g. village fire department): NYC Dept of Health & Mental Hygiene

NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS):

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES: 4

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 7,750

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

DEATHS	0	(Col. G)
DAYS AWAY FROM WORK	0	(Col. H)
JOB TRANSFER OR RESTRICTION	0	(Col. I)
OTHER RECORDABLE CASES	0	(Col. J.)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0	(Col. K)
AWAY FROM WORK	0	(Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	0	(Col. 1)
SKIN DISORDERS	0	(Col. 2)
RESPIRATORY CONDITIONS	0	(Col. 3)
POISONINGS	0	(Col. 4)
ALL OTHER ILLNESSES	0	(Col. 5)

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: Karen S Goldberg TITLE: [illegible] Facilities Mgr.

PRINT NAME: KAREN S. GOLDBERG DATE: 1-16-04

STATE OF NEW YORK
DEPARTMENT OF LABOR

Divison of Safety and Health
Public Employee Safety and Health
State Office Campus
Building 12, Room 158
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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH-900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: NYC-DOHMH / BMIRH	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: ①1826 ARTHUR AVE ②2432 GRAND CONCOURSE	AVERAGE NUMBER OF EMPLOYEES: 9
CITY, STATE, ZIP CODE: BRONX, NY ①10457 ②10458	
INDUSTRY DESCRIPTION (e.g.,village fire department)	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 15,750
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).	

* STAFF OCCUPIED SITE #2 from 1/1/03 - 6/30/03 *

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Haywood Stephney, Sr. TITLE: Site Administrator

PRINT NAME: Haywood Stephney, Sr. DATE: 2/2/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: NYC-DOHMH / BMIRH	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 1727 Amsterdam Ave, 3rd fl.	AVERAGE NUMBER OF EMPLOYEES: 9
CITY, STATE, ZIP CODE: NY, NY 10031	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 15,750
INDUSTRY DESCRIPTION (e.g.,village fire department)	
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Haywood Stephney TITLE Site Administrator

PRINT NAME HAYWOOD STEPHNEY, JR DATE 2/2/04

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division 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

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: Dept of Health + Mental Hygiene

STREET ADDRESS: 465 Hudson Ave

CITY, STATE, ZIP CODE: Brooklyn, N.Y 11201

INDUSTRY DESCRIPTION (e.g., village fire department): Field Office

NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES: 34

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 120,460

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

DEATHS	0 (Col. G)
DAYS AWAY FROM WORK	0 (Col. H)
JOB TRANSFER OR RESTRICTION	0 (Col. I)
OTHER RECORDABLE CASES	0 (Col. J.)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0 (Col. K)
AWAY FROM WORK	0 (Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	0 (Col.1)
SKIN DISORDERS	0 (Col. 2)
RESPIRATORY CONDITIONS	0 (Col. 3)
POISONINGS	0 (Col. 4)
ALL OTHER ILLNESSES	0 (Col. 5)

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: Betty Rhodes TITLE: P.A.A.

PRINT NAME: Betty Rhodes DATE: 2-1-04

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Divison of Safety and Health
Public Employee Safety and Health
State Office Campus
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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH-900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Dept. of Health + Mental Hygiene	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 465 Hudson Ave	AVERAGE NUMBER OF EMPLOYEES: 34
CITY, STATE, ZIP CODE: Brooklyn, N.Y. 11201	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 120,460
INDUSTRY DESCRIPTION (e.g. village fire department): Field Office	
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Betty Rhodes TITLE: P.A.A.

PRINT NAME: Betty Rhodes DATE: 12-19-2003

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Divison of Safety and Health
Public Employee Safety and Health
State Office Campus
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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH-900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: BUSHWICK CHEST CENTER / Nyc Dept. of Health T.B. control	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 335 Central Ave 2nd Floor	AVERAGE NUMBER OF EMPLOYEES: 11
CITY, STATE, ZIP CODE: Brooklyn, N.Y. 11221	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 8,785
INDUSTRY DESCRIPTION (e.g.,village fire department)	
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 R. Coleman TITLE PAA 1

PRINT NAME Robin L. Coleman DATE 12-31-03

STATE OF NEW YORK
DEPARTMENT OF LABOR

Divison of Safety and Health
Public Employee Safety and Health
State Office Campus
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Albany, NY 12240

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: NYC Department of Health and Mental Hygiene - Morrisania Health Center	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 1309 Fulton Avenue	AVERAGE NUMBER OF EMPLOYEES: 5
CITY, STATE, ZIP CODE: Bronx NY 10456	
INDUSTRY DESCRIPTION (e.g., village fire department): Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 10,218
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	1 (Col. 1)
DAYS AWAY FROM WORK	1 (Col. H)	AWAY FROM WORK	1 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORDABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Valerie Bailey TITLE: Health Services Manager

PRINT NAME: Valerie Bailey DATE: 1/30/04

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

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: NYC Department of Health and Mental Hygiene - Tremont Health Center

STREET ADDRESS: 1826 Arthur Avenue

CITY, STATE, ZIP CODE: Bronx, NY 10457

INDUSTRY DESCRIPTION (e.g.,village fire department): Health and Mental Hygiene

NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): ____ ____ ____ ____ ____ ____

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES: 2

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 5039

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

DEATHS	0 (Col. G)
DAYS AWAY FROM WORK	0 (Col. H)
JOB TRANSFER OR RESTRICTION	0 (Col. I)
OTHER RECORDABLE CASES	0 (Col. J.)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0 (Col. K)
AWAY FROM WORK	0 (Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	0 (Col. 1)
SKIN DISORDERS	0 (Col. 2)
RESPIRATORY CONDITIONS	0 (Col. 3)
POISONINGS	0 (Col. 4)
ALL OTHER ILLNESSES	0 (Col. 5)

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: [signature] TITLE: Health Services Manager

PRINT NAME: Valerie Bailey DATE: 1/30/04

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Public Employee Safety and Health
State Office Campus
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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH-900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME NYC Department of Health and Mental Hygiene - Washington Heights Health Center	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 600 West 168 Street	AVERAGE NUMBER OF EMPLOYEES 3
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g., village fire department) Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 6530
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	62 (Col. K)	INJURIES	2 (Col. 1)
DAYS AWAY FROM WORK	2 (Col. H)	AWAY FROM WORK	553 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	1 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORDABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Valerie Bailey TITLE Health Services Manager

PRINT NAME Valerie Bailey DATE 1/30/04

STATE OF NEW YORK
DEPARTMENT OF LABOR

Divison of Safety and Health
Public Employee Safety and Health
State Office Campus
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Albany, NY 12240

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

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: Brownsville Chest Center

STREET ADDRESS: 259 Bristol Street 3FL

CITY, STATE, ZIP CODE: Brooklyn, NY 11212

INDUSTRY DESCRIPTION (e.g., village fire department): Chest Center.

NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): ____ ____ ____ ____ ____ ____

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES: 8

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 1764 hrs

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

DEATHS	0	(Col. G)
DAYS AWAY FROM WORK	0	(Col. H)
JOB TRANSFER OR RESTRICTION	0	(Col. I)
OTHER RECORDABLE CASES	0	(Col. J.)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0	(Col. K)
AWAY FROM WORK	0	(Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	0	(Col. 1)
SKIN DISORDERS	0	(Col. 2)
RESPIRATORY CONDITIONS	0	(Col. 3)
POISONINGS	0	(Col. 4)
ALL OTHER ILLNESSES	0	(Col. 5)

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: Phillip Duah TITLE: Center Administrative Manager

PRINT NAME: Phillip Duah DATE: 12/31/04

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

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 Employees Health Prgm- Chelsea HC	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 303 9th Ave - B34	AVERAGE NUMBER OF EMPLOYEES 10
CITY, STATE, ZIP CODE New York NY 10001	
INDUSTRY DESCRIPTION (e.g. village fire department) NYC Dept of Health	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR $ 7280
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 [signature] TITLE Clinic ADM

PRINT NAME Marinia Rodriguez DATE 2/10/04

SH-900.1 (2-03)

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

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: Bedford Chest Center	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 485 Throop Avenue.	AVERAGE NUMBER OF EMPLOYEES: 32
CITY, STATE, ZIP CODE: Brooklyn NY 11221	
INDUSTRY DESCRIPTION (e.g. village fire department): DOHMH Chest Center.	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 54,650
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	1 (Col. 1)
DAYS AWAY FROM WORK	1 (Col. H)	AWAY FROM WORK	11 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Carrie Williams TITLE PHN II (PCM)

PRINT NAME Carrie Williams DATE 1/5/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: NYC DOHMH - School Health - Region 3	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 1601 Ave S. RM 245	AVERAGE NUMBER OF EMPLOYEES: 240
CITY, STATE, ZIP CODE: Brooklyn, NY 11229	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 309,960
INDUSTRY DESCRIPTION (e.g., village fire department): City's Public Health Agency	
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	6 (Col. 1)
DAYS AWAY FROM WORK	4 (Col. H)	AWAY FROM WORK	9 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORDABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Valerie Valmont TITLE: Asst Reg Mngr

PRINT NAME: Valerie Valmont DATE: 2-10-04

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division 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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME N.Y.C. Dept of Health & Mental Hygiene - Riverside H.C.	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 160 West 100 Street	AVERAGE NUMBER OF EMPLOYEES 120
CITY, STATE, ZIP CODE New York N.Y. 10025	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 164,500
INDUSTRY DESCRIPTION (e.g.,village fire department) HEALTH CARE	
STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN. ____ ____ ____ ____	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

6. CERTIFICATION

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

SIGNATURE Norbert Hearn MD TITLE Health Service Mgr

PRINT NAME N. Hearn DATE 11/29/04

SH-900.1 (12-02)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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

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

mployees, 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. ee 801.35 and instructions for further details on access provisions for these forms.

1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME NYC Dept. of Health Mental Hygiene - Central Harlem H.C.

STREET ADDRESS 2238 Fifth Avenue

ITY, STATE, ZIP CODE New York NY 10035

NDUSTRY DESCRIPTION (e.g., village fire department)

TANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN.

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES: 110

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 169,400

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

3. NUMBER OF CASES

DEATHS	0 (Col. G)
DAYS AWAY FROM WORK	0 (Col. H)
JOB TRANSFER OR RESTRICTION	0 (Col. I)
OTHER RECORD-ABLE CASES	0 (Col. J)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0 (Col. K)
AWAY FROM WORK	0 (Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	0 (Col.1)
SKIN DISORDERS	0 (Col. 3)
RESPIRATORY CONDITIONS	0 (Col. 4)
POISONINGS	0 (Col. 5)
HEARING LOSS	0 (Col. 6)
ALL OTHER ILLNESSES	0 (Col. 7)

6. CERTIFICATION

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

IGNATURE Norbert Ataande TITLE Health Services Mgr

RINT NAME NORBERT ATAANDE DATE 1/27/04

00.1 (11-01)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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

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

mployees, 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. ee 801.35 and instructions for further details on access provisions for these forms.

1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: NYC Dept. of Health Mental Hygiene - East Harlem H.C.

STREET ADDRESS: 158 East 115 Street

ITY, STATE, ZIP CODE: New York NY 10029

NDUSTRY DESCRIPTION (e.g.,village fire department): HEALTH CARE

TANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN.

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES: 130

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 20020

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

3. NUMBER OF CASES

DEATHS	0 (Col. G)
DAYS AWAY FROM WORK	2 (Col. H)
JOB TRANSFER OR RESTRICTION	0 (Col. I)
OTHER RECORDABLE CASES	0 (Col. J)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0 (Col. K)
AWAY FROM WORK	19 (Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	2 (Col. 1)
SKIN DISORDERS	0 (Col. 3)
RESPIRATORY CONDITIONS	0 (Col. 4)
POISONINGS	0 (Col. 5)
HEARING LOSS	0 (Col. 6)
ALL OTHER ILLNESSES	0 (Col. 7)

6. CERTIFICATION

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

GNATURE: Norbert Ahamde TITLE: Health Service Mgr

RINT NAME: NORBERT AHAMDE DATE: 1/27/04

30.1 (11-01)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Operations - Woodside Garage	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 37-50 57th Street	AVERAGE NUMBER OF EMPLOYEES: 32
CITY, STATE, ZIP CODE: Woodside, NY 11377	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 62,455
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept. of Health + Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 488999 492210	

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 ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	0 (Col. K.)	INJURIES	3 (Col. 1)
DAYS AWAY FROM WORK	2 (Col. H.)	JOB TRANSFER OR RESTRICTION	15 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	1 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (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 Christine Abril TITLE PAA

PRINT NAME Christine Abril DATE 2/1/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Operations - Maspeth Garage	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 56-17 56th Road	AVERAGE NUMBER OF EMPLOYEES: 23
CITY, STATE, ZIP CODE: Maspeth, NY 11378	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 43,720
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept. of Health + Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 492210 488490	

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 ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	115 (Col. K.)	INJURIES	2 (Col. 1)
DAYS AWAY FROM WORK	2 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (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: Christine Abril TITLE: PAA

PRINT NAME: Christine Abril DATE: 2/1/05

SH 900.1 (12-03)

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

2003

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 N.Y.C. DOH/MH Bureau of Maternal Infant & Reproductive Health	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 164-19 Hillside Ave 1st Floor.	AVERAGE NUMBER OF EMPLOYEES 16
CITY, STATE, ZIP CODE Jamaica N.Y. 11432	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 28,000
INDUSTRY DESCRIPTION (e.g.,village fire department) NYC DOHMH	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS). 923120	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	3 (Col.1)
DAYS AWAY FROM WORK	2 (Col. H)	AWAY FROM WORK	33 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	1 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 J Palmer TITLE (Acting) Site Administrator

PRINT NAME Joy Palmer. DATE 2/02/04

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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

2003

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

ESTABLISHMENT NAME New York City Dept. of Health and Mental Hygiene
Washington Heights Chest Center

STREET ADDRESS
600 West 168th Street 2/3rd fl

CITY, STATE, ZIP CODE
New York, New York 10032

INDUSTRY DESCRIPTION (e.g., village fire department)
Public Health

STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN. NAICS
923120

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES
26

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR

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

DEATHS	0 (Col. G)
DAYS AWAY FROM WORK	0 (Col. H)
JOB TRANSFER OR RESTRICTION	0 (Col. I)
OTHER RECORDABLE CASES	0 (Col. J)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0 (Col. K)
AWAY FROM WORK	0 (Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	0 (Col. 1)
SKIN DISORDERS	0 (Col. 3)
RESPIRATORY CONDITIONS	0 (Col. 4)
POISONINGS	0 (Col. 5)
HEARING LOSS	0 (Col. 6)
ALL OTHER ILLNESSES	0 (Col. 7)

6. CERTIFICATION

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

SIGNATURE Marci W. Valentine
TITLE Center Administrative Manager

PRINT NAME Marci W. Valentine
DATE 1/30/04

SH-900.1 (11-01) old form.

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME NYC DEPARTMENT OF HEALTH AND MENTAL HYGIENE/VETERINARY & PEST CONTROL	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 WORTH STREET, ROOM 619	AVERAGE NUMBER OF EMPLOYEES 60
CITY, STATE, ZIP CODE NEW YORK NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 12,000
INDUSTRY DESCRIPTION (e.g.. village fire department) HEALTH DEPARTMENT	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120	

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 ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	0 (Col. K.)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (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 Delia Payne TITLE RESEARCH ASSISTANT

PRINT NAME DELIA PAYNE DATE 2/9/2004

SH 900.1 (12-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Bureau of HIV/AIDS	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 40 Worth St. 15th Fl.	AVERAGE NUMBER OF EMPLOYEES: 60
CITY, STATE, ZIP CODE: N.Y., N.Y. 10013	
INDUSTRY DESCRIPTION (e.g., village fire department): New York City Dept. of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 102,815
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 9 2 3 1 2 0	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORDABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Saundra P. Gilkes TITLE Health & Safety Officer, ASA

PRINT NAME SAUNDRA P. GILKES DATE 2/5/04

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

2003

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: TB Control Brooklyn Field Office	If you don't have accurate figures, see the instructions on the back of this sheet. Not Completed.
STREET ADDRESS: 465 Hudson Avenue	AVERAGE NUMBER OF EMPLOYEES: _____
CITY, STATE, ZIP CODE: Brooklyn NY 11225	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: _____
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC DOHMH	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 _____

SH-900.1 (2-03)

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

2003

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Brownsville Chest Center	If you don't have accurate figures, see the instructions on the back of this sheet. Not Completed.
STREET ADDRESS: 259 Bristol St	AVERAGE NUMBER OF EMPLOYEES:
CITY, STATE, ZIP CODE: Brooklyn NY 11212	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR:
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC DOHMH	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	(Col. 5)

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 _____

STATE OF NEW YORK
DEPARTMENT OF LABOR

Divison of Safety and Health
Public Employee Safety and Health
State Office Campus
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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH-900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: SOUTH BROOKLYN PEST CONTROL.	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 1075 RALPH AVE, Floors 1 & B.	AVERAGE NUMBER OF EMPLOYEES: 36
CITY, STATE, ZIP CODE: BROOKLYN N.Y. 11236	
INDUSTRY DESCRIPTION (e.g., village fire department): DEPT OF HEALTH AND MENTAL HYGIENE	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 50400
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 561710 561110 488490	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	2 (Col. 1)
DAYS AWAY FROM WORK	2 (Col. H)	AWAY FROM WORK	36 (Col. K)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORDABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)
				Hearing Loss	0 Col 5

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: Browne — TITLE: Act Regional Director.

PRINT NAME: OSWALD BROWNE — DATE: 1-6-04

SH-900.1 (2-03)

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

2003

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Bedford Chest Center	If you don't have accurate figures, see the instructions on the back of this sheet. None Submitted.
STREET ADDRESS: 485 Throop Avenue	AVERAGE NUMBER OF EMPLOYEES: _____
CITY, STATE, ZIP CODE: Brooklyn NY 11221	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: _____
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	1 (Col.1)
DAYS AWAY FROM WORK	1 (Col. H)	AWAY FROM WORK	77 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 _____

STATE OF NEW YORK
DEPARTMENT OF LABOR

Divison of Safety and Health
Public Employee Safety and Health
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Albany, NY 12240

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

2002

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Corona Chest Center	If you don't have accurate figures, see the instructions on the back of this sheet. None Submitted.
STREET ADDRESS: 59-17 Junction Blvd	AVERAGE NUMBER OF EMPLOYEES: _____
CITY, STATE, ZIP CODE: Jackson Hghts NY 11367	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: _____
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	2 (Col.1)
DAYS AWAY FROM WORK	2 (Col. H)	AWAY FROM WORK	12 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 _____

STATE OF NEW YORK
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Divison of Safety and Health
Public Employee Safety and Health
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Albany, NY 12240

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

2003

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Ft Greene Chest Center	If you don't have accurate figures, see the instructions on the back of this sheet. None Submitted
STREET ADDRESS: 295 Flatbush Ave Ext	AVERAGE NUMBER OF EMPLOYEES: _____
CITY, STATE, ZIP CODE: Brooklyn NY 11201	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: _____
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	2 (Col.1)
DAYS AWAY FROM WORK	1 (Col. H)	AWAY FROM WORK	1 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	1 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 _____

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SH-900.1 (2-03)

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

2003

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Bushwick Chest Center	If you don't have accurate figures, see the instructions on the back of this sheet. None Submitted
STREET ADDRESS: 335 Central Ave 2nd Fl	AVERAGE NUMBER OF EMPLOYEES: _____
CITY, STATE, ZIP CODE: Brooklyn NY 11221	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: _____
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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SIGNATURE _____ TITLE _____

PRINT NAME _____ DATE _____

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DEPARTMENT OF LABOR

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Public Employee Safety and Health
State Office Campus
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2003

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Bureau of TB Control - Admin Office	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 Worth St 2nd Fl	Not Submitted AVERAGE NUMBER OF EMPLOYEES: _____
CITY, STATE, ZIP CODE: New York NY 10013	
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: _____
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

6. CERTIFICATION

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SIGNATURE _____ TITLE _____

PRINT NAME _____ DATE _____

SH-900.1 (2-03)

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: TB Control East Side Shelter	If you don't have accurate figures, see the instructions on the back of this sheet. Not Submitted
STREET ADDRESS: 400 - 430 East 30th St	AVERAGE NUMBER OF EMPLOYEES: _____
CITY, STATE, ZIP CODE: New York NY 10016	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: _____
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

6. CERTIFICATION

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SIGNATURE _____ TITLE _____

PRINT NAME _____ DATE _____

SH-900.1 (2-03)

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2003

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Atlantic Shelter TB Control	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 1322 Bedford Avenue	Not Submitted AVERAGE NUMBER OF EMPLOYEES: _____
CITY, STATE, ZIP CODE: Brooklyn NY 11216	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: _____
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Ft Greene Chest Center	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 295 Flatbush Ave Ext	Not Submitted AVERAGE NUMBER OF EMPLOYEES: _____
CITY, STATE, ZIP CODE: Brooklyn NY 11201	
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: _____
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	2 (Col.1)
DAYS AWAY FROM WORK	1 (Col. H)	AWAY FROM WORK	1 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	1 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

6. CERTIFICATION

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SIGNATURE _____ TITLE _____

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SH-900.1 (2-03)

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2003

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Richmond Chest Center	If you don't have accurate figures, see the instructions on the back of this sheet. Not Submitted.
STREET ADDRESS: 51 Stuyvesant Pl	AVERAGE NUMBER OF EMPLOYEES: _____
CITY, STATE, ZIP CODE: Staten Is NY 10301	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: _____
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 _____

SH-900.1 (2-03)

DEPARTMENT OF LABOR

Public Safety and Health Bureau
State Office Campus
Building 12, Room 158
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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH-900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME NYC DOHMH LOWER MANHATTAN HEALTH CENTER/OPERATIONS	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 303 NINTH AVENUE	AVERAGE NUMBER OF EMPLOYEES 5.25
CITY, STATE, ZIP CODE NEW YORK, N.Y. 10001	
INDUSTRY DESCRIPTION (e.g.,village fire department) PUBLIC HEALTH CLINIC	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 9,446.5
STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN. ____ ____ ____ ____	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 3)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 4)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 5)
				HEARING LOSS	0 (Col. 6)
				ALL OTHER ILLNESSES	0 (Col. 7)

6. CERTIFICATION

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

SIGNATURE Kevin M. McGrath TITLE HEALTH SERVICES MANAGER

PRINT NAME KEVIN McGRATH DATE 1/30/04

DEPARTMENT OF LABOR

Public S
State
Buildin
Albany, N

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

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

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 equ
See 801.35 and instructions for further details on access provisions for these forms.

1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME NYC DOHMH JAMAICA HEALTH CENTER /OPERATIONS	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 90-37 PARSONS BOULEVARD	AVERAGE NUMBER OF EMPLOYEES 4.2
CITY, STATE, ZIP CODE JAMAICA, N.Y. 11432	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 7,391.5
INDUSTRY DESCRIPTION (e.g.,village fire department) PUBLIC HEALTH CLINIC	
STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN. ____ ____ ____ ____	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 3)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 4)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 5)
				HEARING LOSS	0 (Col. 6)
				ALL OTHER ILLNESSES	0 (Col. 7)

6. CERTIFICATION

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

SIGNATURE Kevin McGrath TITLE HEALTH SERVICES MANAGER

PRINT NAME KEVIN McGRATH DATE 1/30/04

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME HIV Training Institute Bureau of HIV/AIDS Hyc. Dohmh	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 40 worth Street	AVERAGE NUMBER OF EMPLOYEES 17
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g., village fire department) Education/Training Unit	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 30,940
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	1 (Col.1)
DAYS AWAY FROM WORK	1 (Col. H)	AWAY FROM WORK	1 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Sandra Frazier TITLE ASA

PRINT NAME Sandra Frazier DATE 2/2/04

SH-900.1 (2-03)

DEPARTMENT OF LABOR

Public Safety and Health Bureau
State Office Campus
Building 12, Room 158
Albany, NY 12240

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME NYCDOHMH CORONA HEALTH CENTER / OPERATIONS	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 34-33 JUNCTION BOULEVARD	AVERAGE NUMBER OF EMPLOYEES 5.90
CITY, STATE, ZIP CODE JACKSON HEIGHTS, N.Y. 11372	
INDUSTRY DESCRIPTION (e.g., village fire department) PUBLIC HEALTH CLINIC	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 9,647.5
STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN. ____ ____ ____ ____	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 3)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 4)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 5)
				HEARING LOSS	0 (Col. 6)
				ALL OTHER ILLNESSES	0 (Col. 7)

6. CERTIFICATION

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

SIGNATURE Kevin McGrath TITLE HEALTH SERVICES MANAGER

PRINT NAME KEVIN McGRATH DATE 1/30/04

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: DIVISION OF MENTAL HYGIENE & BORO OFFICES*	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 93 WORTH STREET	AVERAGE NUMBER OF EMPLOYEES: 556
CITY, STATE, ZIP CODE: NEW YORK, NY 10013	
INDUSTRY DESCRIPTION (e.g.,village fire department): MUNICIPAL CITY AGENCY	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 924,300
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 5611	

* ALL BORO OFFICES RELOCATED TO 93 WORTH STREET

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Stephen Farrell TITLE: DIRECTOR

PRINT NAME: STEPHEN FARRELL DATE: FEBRUARY 25, 2004

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

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME DOHMH / Bureau Maternal, Infant & Reproductive Health	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 2 Lafayette Street, 18th Floor	AVERAGE NUMBER OF EMPLOYEES 21
CITY, STATE, ZIP CODE New York, NY 10007	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 19,110.
INDUSTRY DESCRIPTION (e.g., village fire department) Health Department	
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 JoAnna Quinn TITLE Office Manager

PRINT NAME JOANNA QUINN DATE 2/20/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: HUMAN RESOURCES — Admin / Processing/Benefits ID unit / Personnel Services Office of the Commissioner	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 WORTH ST, Rm 900, 908, 910, 911 — 912, 914, 915	AVERAGE NUMBER OF EMPLOYEES: 44 *
CITY, STATE, ZIP CODE: NEW YORK NY 10013	
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 80,250
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 5611	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	1 (Col.1)
DAYS AWAY FROM WORK	1 (Col. H)	AWAY FROM WORK	1 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Ramlakhan — TITLE: H&S Compliance Inspector

PRINT NAME: INGRID RAMLAKHAN — DATE: 1/30/04

SH-900.1 (2-03)

* Some employees formerly of 93 Worth St Mental Hygiene HR

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Human Resources- Labor Relations Teams / H&S	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 Worth Street Rm 930	AVERAGE NUMBER OF EMPLOYEES: 42
CITY, STATE, ZIP CODE: New York NY 10013	
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 72500
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 5611	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: I Ramlakhan TITLE: H & S Compliance Insp.

PRINT NAME: INGRID RAMLAKHAN DATE: 1/30/04

SH-900.1 (2-03) * Employees formerly from Rm 1047, 1010, 1012, 908 of 125 Worth St from 346 B'way Rm 832 from 93 Worth St Rm 1181

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: N.Y.C Early Intervention Program	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 16 Court St. 2nd floor.	AVERAGE NUMBER OF EMPLOYEES: 63
CITY, STATE, ZIP CODE: Brooklyn N.Y 11241	
INDUSTRY DESCRIPTION (e.g., village fire department): N.Y.C D.H and M.H	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 108445
STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN: ____ ____ ____ ____	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

6. CERTIFICATION

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

SIGNATURE Jim Peters TITLE Coordinating mgr.

PRINT NAME Sim Peters DATE 3/18/04

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: Richmond Health Care

STREET ADDRESS: 51 Stuyvesant Place

CITY, STATE, ZIP CODE: Staten Island, NY 10301

INDUSTRY DESCRIPTION (e.g., village fire department): Health Facility

STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN: ____ ____ ____ ____

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES: 40

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST Y: 35

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

DEATHS	0	(Col. G)
DAYS AWAY FROM WORK	0	(Col. H)
JOB TRANSFER OR RESTRICTION	0	(Col. I)
OTHER RECORDABLE CASES	0	(Col. J)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0	(Col. K)
AWAY FROM WORK	0	(Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	0	(Col. 1)
SKIN DISORDERS	0	(Col. 3)
RESPIRATORY CONDITIONS	0	(Col. 4)
POISONINGS	0	(Col. 5)
HEARING LOSS	0	(Col. 6)
ALL OTHER ILLNESSES	0	(Col. 7)

6. CERTIFICATION

I certify that I have examined this document and that to the best of my acknowledge the entries are true, accurate, and complet

SIGNATURE: Karen Goldberg TITLE: Assist. Facilities Mgr.

PRINT NAME: Karen Goldberg DATE: 1/16/04

SH-900.1 (11-01)

DEPARTMENT OF LABOR

Public Safety and Health Bureau
State Office Campus
Building 12, Room 158
Albany, NY 12240

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME NYCDOHMH ASTORIA HEALTH CENTER / OPERATIONS	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 12-26 31st AVENUE	AVERAGE NUMBER OF EMPLOYEES 4.5
CITY, STATE, ZIP CODE ASTORIA, NY 11106	
INDUSTRY DESCRIPTION (e.g., village fire department) PUBLIC HEALTH CLINIC	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 7,882-5
STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN. ____ ____ ____ ____	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 3)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 4)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 5)
				HEARING LOSS	0 (Col. 6)
				ALL OTHER ILLNESSES	0 (Col. 7)

6. CERTIFICATION

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

SIGNATURE Kevin Mc Grath TITLE HEALTH SERVICE MANAGER

PRINT NAME KEVIN Mc GRATH DATE 1/30/04

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: NYC DOHMH Bureau of Tuberculosis

STREET ADDRESS: 253 Broadway

CITY, STATE, ZIP CODE: New York, N.Y. 10007

INDUSTRY DESCRIPTION (e.g., village fire department): Education + TRAINING

STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN.

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES: 6

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEA: 35 per wk x 6 x. 10920 hrs

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

DEATHS	0 (Col. G)
DAYS AWAY FROM WORK	0 (Col. H)
JOB TRANSFER OR RESTRICTION	0 (Col. I)
OTHER RECORDABLE CASES	0 (Col. J)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0 (Col. K)
AWAY FROM WORK	0 (Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	0 (Col. 1)
SKIN DISORDERS	0 (Col. 3)
RESPIRATORY CONDITIONS	0 (Col. 4)
POISONINGS	0 (Col. 5)
HEARING LOSS	0 (Col. 6)
ALL OTHER ILLNESSES	0 (Col. 7)

6. CERTIFICATION

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

SIGNATURE: Valerie L. Gunn TITLE: ASA

PRINT NAME: Valerie Gunn DATE: 3/23/04

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME New York City Dept of Health and Mental Hygiene
Washington Heights Chest Center

STREET ADDRESS
600 West 168th Street 2/3rd fl

CITY, STATE, ZIP CODE
New York, New York 10032

INDUSTRY DESCRIPTION (e.g., village fire department)
Public Health

STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN.
____ ____ ____ ____

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES
26

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR

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

DEATHS	0 (Col. G)
DAYS AWAY FROM WORK	0 (Col. H)
JOB TRANSFER OR RESTRICTION	0 (Col. I)
OTHER RECORDABLE CASES	0 (Col. J)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0 (Col. K)
AWAY FROM WORK	0 (Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	0 (Col. 1)
SKIN DISORDERS	0 (Col. 3)
RESPIRATORY CONDITIONS	0 (Col. 4)
POISONINGS	0 (Col. 5)
HEARING LOSS	0 (Col. 6)
ALL OTHER ILLNESSES	0 (Col. 7)

6. CERTIFICATION

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

SIGNATURE Marci W. Valentine TITLE Center Administrative Manager

PRINT NAME Marci W. Valentine DATE 11/30/04

STATE OF NEW YORK
DEPARTMENT OF LABOR

Divison of Safety and Health
Public Employee Safety and Health
State Office Campus
Building 12, Room 168
Albany, NY 12240

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

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: NYC DOHMH - Bureau of School Health	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 120-34 Queens Blvd, 3rd floor	AVERAGE NUMBER OF EMPLOYEES: 308
CITY, STATE, ZIP CODE: Kew Gardens, NY 11415	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 10,276
INDUSTRY DESCRIPTION (e.g., village fire department): Regional Office (Region 5)	
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	19 (Col.1)
DAYS AWAY FROM WORK	13 (Col. H)	AWAY FROM WORK	58 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	3 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Richard Fox TITLE: Regional Manager

PRINT NAME: Richard Fox DATE: 2/17/04

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Divison of Safety and Health
Public Employee Safety and Health
State Office Campus
Building 12, Room 153
Albany, NY 12240

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

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: BROWNSVILLE HEALTH CENTER	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 259 BRISTOL STREET	AVERAGE NUMBER OF EMPLOYEES: 4
CITY, STATE, ZIP CODE: BROOKLYN, N.Y. 11212	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 7,830
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Dept of Health & Mental Hygiene	
STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN.	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

6. CERTIFICATION

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

SIGNATURE: Ricardo M. Baker
TITLE: Administrative Mngr.
PRINT NAME: RICARDO M. BAKER
DATE: 6-29-04

SH-900.1 (12-02)

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

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: Public Health Training & Injury Epidemiology	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 2 Lafayette Street – 20th floor	AVERAGE NUMBER OF EMPLOYEES: 24
CITY, STATE, ZIP CODE: New York, NY 10007	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 37500
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 9 5 2 6 3 1 1 1 2 0	

Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900 for each category (columns 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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORDABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Calaine Hemans-Henry TITLE Epidemiologist

PRINT NAME CALAINE HEMANS-HENRY DATE 4/28/04

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division 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

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

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME
Public Health Library

STREET ADDRESS
455 1st Avenue – 12th floor

CITY, STATE, ZIP CODE
New York, NY 10016

INDUSTRY DESCRIPTION (e.g., village fire department)
NYC Dept of Health & Mental Hygiene

NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).
5 6 1 1 ___ ___

2. EMPLOYMENT INFORMATION

If you don't have accurate figures see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES
10

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
9800

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

DEATHS	0	(Col. G)
DAYS AWAY FROM WORK	0	(Col. H)
JOB TRANSFER OR RESTRICTION	0	(Col. I)
OTHER RECORDABLE CASES	0	(Col. J.)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0	(Col. K)
AWAY FROM WORK	0	(Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	0	(Col.1)
SKIN DISORDERS	0	(Col. 2)
RESPIRATORY CONDITIONS	0	(Col. 3)
POISONINGS	0	(Col. 4)
ALL OTHER ILLNESSES	0	(Col. 5)

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 Calaine Hemans-Henry TITLE City Research Scientist

PRINT NAME CALAINE HEMANS-HENRY DATE 4/15/2004

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME
HUMAN RESOURCES Admin / Processing / Benefits ID unit / Personnel Services Office of the Commissioner

STREET ADDRESS
125 WORTH ST, Rm 908, 910, 911 912, 914, 915

CITY, STATE, ZIP CODE
NEW YORK NY 10013

INDUSTRY DESCRIPTION (e.g., village fire department)
NYC Dept of Health & Mental Hygiene

NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).
923120 5611 ____ ____ ____

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES
44

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
80,250

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

DEATHS	0 (Col. G)
DAYS AWAY FROM WORK	1 (Col. H)
JOB TRANSFER OR RESTRICTION	0 (Col. I)
OTHER RECORD-ABLE CASES	0 (Col. J.)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0 (Col. K)
AWAY FROM WORK	1 (Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	1 (Col.1)
SKIN DISORDERS	0 (Col. 2)
RESPIRATORY CONDITIONS	0 (Col. 3)
POISONINGS	0 (Col. 4)
ALL OTHER ILLNESSES	0 (Col. 5)

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 Ramlakhan TITLE H&S Compliance Inspector

PRINT NAME INGRID RAMLAKHAN DATE 1/30/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: NYC DOHMH STD Control	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: *125 WORTH ST Rm 207 BOX 73	AVERAGE NUMBER OF EMPLOYEES: 235
CITY, STATE, ZIP CODE: New York, N.Y. 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 394,800
INDUSTRY DESCRIPTION (e.g., village fire department): Diagnostic & Treatment Centers	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS):	

* Central Office Address - 12 field sites in 5 boros on attached SH 900 logs.

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	17 (Col. 1)
DAYS AWAY FROM WORK	6 (Col. H)	AWAY FROM WORK	39.4 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	9 (Col. 3)
OTHER RECORDABLE CASES	20 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Linda Brown TITLE: Program Planner

PRINT NAME: Linda BROWN DATE: 1/23/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME NYC EARLY INTERVENTION PROGRAM	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 49-51 CHAMBERS STREET - ROOM 1033	AVERAGE NUMBER OF EMPLOYEES 20
CITY, STATE, ZIP CODE NEW YORK, NEW YORK 10007	
INDUSTRY DESCRIPTION (e.g.,village fire department) NEW YORK CITY DOH&MH	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 33,250
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Barbara Pouncy TITLE Coordinating Manager

PRINT NAME BARBARA POUNCY DATE January 15, 2004

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Commissioner's Office	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 Worth St. Rm 331 - CN 29A	AVERAGE NUMBER OF EMPLOYEES: 18
CITY, STATE, ZIP CODE: New York, NY. 10013	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept. of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 35,800
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORDABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Gloria Murphy TITLE: PHD

PRINT NAME: GLORIA MURPHY DATE: 01/28/2004

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Human Resources- Labor Relations Teams / H&S	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 Worth Street Rm 930	AVERAGE NUMBER OF EMPLOYEES: 42
CITY, STATE, ZIP CODE: New York NY 10013	
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 72500
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 5611	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: I Ramlakhan TITLE: H & S Compliance Insp.

PRINT NAME: INGRID RAMLAKHAN DATE: 1/30/04

SH-900.1 (2-03) * Employees formerly from Rm 1047, 1010, 1012, 908 of 125 Worth St from 346 B'way Rm 832 from 93 Worth St Rm 1121

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

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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 Division of Financial & Strategic Mgmt NYC Department of Health + Mental Hygiene	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 125 Worth St, Rm 620	AVERAGE NUMBER OF EMPLOYEES 7
CITY, STATE, ZIP CODE NY, NY 10013	
INDUSTRY DESCRIPTION (e.g.,village fire department) Public health department	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 14,355
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Jennifer Mandel TITLE PMO

PRINT NAME Jennifer Mandel DATE 1/28/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME Bureau of Pest Control North Brooklyn	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 130 Nostrand Ave	AVERAGE NUMBER OF EMPLOYEES 49
CITY, STATE, ZIP CODE Brooklyn NY 11205	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 86,580
INDUSTRY DESCRIPTION (e.g.,village fire department) NYC Dept of Health & Mental Hygiene	
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	3 (Col.1)
DAYS AWAY FROM WORK	3 (Col. H)	AWAY FROM WORK	38 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Vincent R Colbourne TITLE Regional Director

PRINT NAME Vincent R. Colbourne DATE 2/2/04

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division 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

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"2003" 1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: FAR ROCKAWAY CHEST CENTER	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 67-10 Rockaway Beach Blvd. RM 201	AVERAGE NUMBER OF EMPLOYEES: 8
CITY, STATE, ZIP CODE: Far Rockaway, N.Y. 11692	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 4,700
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 CLINIC MANAGER

PRINT NAME LUZ CRISMALI DATE 01-30-2004

SH-900.1 (2-03)

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

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.

"2003" 1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: CORONA CHEST CENTER	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 34-33 Junction Blvd, 2nd Flour	AVERAGE NUMBER OF EMPLOYEES: 54
CITY, STATE, ZIP CODE: Jackson Hts, NY 11372	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 93,468
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	1 (Col. 1)
DAYS AWAY FROM WORK	3 (Col. H)	AWAY FROM WORK	39 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORDABLE CASES	1 (Col. J)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	3 (Col. 5)

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 CLINIC MGR

PRINT NAME LUZ CRISMALI DATE 1/30/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: HUMAN RESOURCES – WEP UNIT	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 346 Broadway Rm 708.	AVERAGE NUMBER OF EMPLOYEES: 5
CITY, STATE, ZIP CODE: New York NY 10013	
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 7,700
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 5611	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	122 (Col. K)	INJURIES	1 (Col.1)
DAYS AWAY FROM WORK	1 (Col. H)	AWAY FROM WORK	3 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	1 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Ramlakhan TITLE: H&S Compliance Inspector

PRINT NAME: INGRID RAMLAKHAN DATE: 1/30/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Bureau of Communicable Disease	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 Worth Street Rm 225 & 300	AVERAGE NUMBER OF EMPLOYEES: 66
CITY, STATE, ZIP CODE: New York, NY 11001	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept. of Health + Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 119,098 hrs.
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Admin. Dir.

PRINT NAME Vera M. Thorn DATE 1/3/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME NYC DOHMH - Policy + Planning / FSM	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 125 Worth Street, Rm 6-24	AVERAGE NUMBER OF EMPLOYEES 17
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.,village fire department) Health Department	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 29,800
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	3 (Col. 5)

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 Dodsey Cyrus TITLE PAA

PRINT NAME DODSEY CYRUS DATE 1/7/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: Health Promotion & Disease Prevention Administration

STREET ADDRESS: 125 Worth Street, Room 348

CITY, STATE, ZIP CODE: Brooklyn, NY 10013

INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Department of Health / Mental Hygiene

NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES: 16

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 26,669

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

DEATHS	0 (Col. G)
DAYS AWAY FROM WORK	0 (Col. H)
JOB TRANSFER OR RESTRICTION	0 (Col. I)
OTHER RECORDABLE CASES	0 (Col. J.)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0 (Col. K)
AWAY FROM WORK	0 (Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	0 (Col. 1)
SKIN DISORDERS	0 (Col. 2)
RESPIRATORY CONDITIONS	0 (Col. 3)
POISONINGS	0 (Col. 4)
ALL OTHER ILLNESSES	0 (Col. 5)

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: Lisa A. White TITLE: PAA I

PRINT NAME: Lisa A. White DATE: 01-12-04

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME Division of Epidemiology Bu. of Surveillance, Bu. of Epidemiology Services STREET ADDRESS 125 WORTH STREET RMS. 201, 202, 300, 315 CITY, STATE, ZIP CODE NY, NY 10013 CN6 INDUSTRY DESCRIPTION (e.g.,village fire department) NYC Dept. of Health + Mental Hygiene NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS). _____ _____ _____ _____ _____ _____	If you don't have accurate figures, see the instructions on the back of this sheet. AVERAGE NUMBER OF EMPLOYEES 74 TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 135,000

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	0 (Col. G)	AWAY FROM WORK	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	JOB TRANSFER OR RESTRICTION	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (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 John F. Prior TITLE DHRL

PRINT NAME John F. Prior DATE 3-11-04

SH-900.1 (12-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Ft. Greene Chest Center / Bureau of TB Control	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 295 Flatbush Avenue Ext, 4th Floor	AVERAGE NUMBER OF EMPLOYEES: 40
CITY, STATE, ZIP CODE: Brooklyn, NY 11201	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 67,200
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	2 (Col. 1)
DAYS AWAY FROM WORK	1 (Col. H)	AWAY FROM WORK	1 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORDABLE CASES	1 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: David T. Cappelli TITLE: Center Adm. Manager

PRINT NAME: David T. Cappelli DATE: 12/24/03

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: HUMAN RESOURCES- STAFF DEVELOPMENT & TRAINING	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 346 Broadway Rm 832	AVERAGE NUMBER OF EMPLOYEES: 7 *
CITY, STATE, ZIP CODE: New York NY 10013	
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 12,250
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 5611	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	1 (Col. H)	AWAY FROM WORK	2 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	1 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: IRamlakhan TITLE: H&S Compliance Inspector

PRINT NAME: INGRID RAMLAKHAN DATE: 1/30/04

SH-900.1 (2-03) * 2 Employees are formerly of 125 Worth St Rm 1047

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

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: ENVIRON MENTAL HEALTH PEST CONTROL - JAMAICA

STREET ADDRESS: 120-34 Queens Blvd Rm 426

CITY, STATE, ZIP CODE: New York, New York 11415

INDUSTRY DESCRIPTION (e.g., village fire department): NYC. Dept of Health & Mental Hygiene

NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES: 40

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 64,980

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

DEATHS	0	(Col. G)
DAYS AWAY FROM WORK	1	(Col. H)
JOB TRANSFER OR RESTRICTION	0	(Col. I)
OTHER RECORD-ABLE CASES	0	(Col. J.)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0	(Col. K)
AWAY FROM WORK	5	(Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	0	(Col. 1)
SKIN DISORDERS	1	(Col. 2)
RESPIRATORY CONDITIONS	0	(Col. 3)
POISONINGS	0	(Col. 4)
ALL OTHER ILLNESSES	0	(Col. 5)

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: Deborah Bacon TITLE: Office Manager

PRINT NAME: Deborah BACON DATE: 1-24-04

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Bedford Chest Center	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 485 Throop Avenue, 3rd floor	AVERAGE NUMBER OF EMPLOYEES: 32
CITY, STATE, ZIP CODE: Brooklyn NY 11221	
INDUSTRY DESCRIPTION (e.g. village fire department): DOHMH Chest Center.	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 54,650
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	2 (Col. 1)
DAYS AWAY FROM WORK	1 (Col. H)	AWAY FROM WORK	77 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORDABLE CASES	1 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Carnie Williams TITLE: PHN II (PCM)

PRINT NAME: Carnie Williams DATE: 1/5/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Operations - Customer Serv/ Telecommunication	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 Worth Street, Rm. 1003 + 1020	AVERAGE NUMBER OF EMPLOYEES: 20
CITY, STATE, ZIP CODE: New York, NY 10013	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept. of Health + Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 36,020
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		ND ILLNESS TYPES	
DEATHS	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Christine Abril TITLE: PAA

PRINT NAME: Christine Abril DATE: 2/27/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: Operations - Maspeth Garage

STREET ADDRESS: 56-17 56th Drive

CITY, STATE, ZIP CODE: Maspeth NY 11378

INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept. of Health + Mental Hygiene

NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): ____ ____ ____ ____ ____ ____

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES: 24

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 45,839

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

DEATHS	0 (Col. G)
DAYS AWAY FROM WORK	1 (Col. H)
JOB TRANSFER OR RESTRICTION	0 (Col. I)
OTHER RECORDABLE CASES	0

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0 (Col. K)
AWAY FROM WORK	321 (Col. L)

5. INJURIES AND ILLNESS TYPES

SKIN DISORDERS	1 (Col. 1)
RESPIRATORY CONDITIONS	0 (Col. 2)
POISONINGS	0 (Col. 3)
ALL OTHER ILLNESSES	0 (Col. 4)
	0 (Col. 5)

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: Christine Abril TITLE: PAA

PRINT NAME: Christine Abril DATE: 2/27/04

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

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: Operations - Woodside Garage

STREET ADDRESS: 37-50 57th Street

CITY, STATE, ZIP CODE: Woodside, NY 11377

INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept. of Health + Mental Hygiene

NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES: 38

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 73,252

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

3. NUMBER OF CASES

DEATHS	0 (Col. G)
[illegible] WORK	4 (Col. H)
JOB TRANSFER OR RESTRICTION	0 (C
OTHER RECORDABLE CASES	0 (Col. J.)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0 (Col. K)
AWAY FROM	48 (Col. L)

5. [illegible] NESS TYPES

INJURIES	4 (C
SKIN DISORDERS	0 (Col. 2)
RESPIRATORY CONDITIONS	0 (Col. 3)
[illegible] SONINGS	0 (Col. 4)
ALL OTHER ILLNESSES	0 ... 5)

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: Christine Abril TITLE: PAA

PRINT NAME: Christine Abril DATE: 2/27/04

SH-900.1 (2-03)

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

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: Operations - Graphics	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 Worth Street, Rm. 1027	AVERAGE NUMBER OF EMPLOYEES: 2
CITY, STATE, ZIP CODE: New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Dept of Health + Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 7,000
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS):	

Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each category (col[illegible]der each line correspond to the colu[illegible] the Log). If a category has no cases, enter "0."

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND [illegible] TYPES	
DEATHS	0 (Col. G)	JOB TRANSFER OR RESTRICTION	6 (Col. K)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SK[illegible]ORDERS	0 (Col. 2)
JOB TRANSFER [illegible]RICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				[illegible] OTHER ILLNESSES	0 (Col. 5)

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: Christine Abril TITLE: PAA

PRINT NAME: Christine Abril DATE: 2/27/04

SH-900.1 (2-03)

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

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

ESTABLISHMENT NAME: Operations - Architecture + Engineering

STREET ADDRESS: 2 LaFayette Street, 18th Floor

CITY, STATE, ZIP CODE: New York, NY 10013

INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept. of Health + Mental Hygiene

NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS):

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES: 15

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 26,250

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...

3. NUMBER OF CASES

DEATHS	0 (Col. G)
DAYS AWAY FROM WORK	0 (Col. H)
JOB TRANSFER OR RESTRICTION	0 (Col. I)
OTHER RECORDABLE CASES	0 (Col. J.)

4. NUMBER OF DAYS

	0 (Col. K)
AWAY FROM WORK	0 (Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	0 (Col. 1)
SKIN DISORDERS	0 (Col. 2)
RESPIRATORY CONDITIONS	0 (Col. 3)
POISONINGS	0 (Col. 4)
ALL OTHER ILLNESSES	0 (Col. 5)

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: Christine Abril TITLE: PAA

PRINT NAME: Christine Abril DATE: 2/27/04

SH-900.1 (2-03)

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

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: Operations - Reproduction Unit	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 Worth Street, Basement	AVERAGE NUMBER OF EMPLOYEES: 13
CITY, STATE, ZIP CODE: New York, NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 23750
INDUSTRY DESCRIPTION (e.g., village fire department): NYC. Dept. of Health & Mental Hygiene	
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 th... Log). If a category has no cases, enter "0."

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESS...S	
DEATHS	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	...URIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
...NSES	0 (Col. ...)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Christine Abril TITLE: PAA

PRINT NAME: Christine Abril DATE: 2/27/04

SH-900.1 (2-03)

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

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: Operations - Plant Operations	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 455 1st Avenue, Rm. 047	AVERAGE NUMBER OF EMPLOYEES: 40
CITY, STATE, ZIP CODE: New York NY 10016	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 76849
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept. of Health & Mental Hygiene	
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 u: 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	0	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	3 (Col. 1)
DAYS AWAY FROM WORK	3 (Col. H)	AWAY FROM WORK	151	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORDABLE CASES	0			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Christine Abril TITLE: PAA

PRINT NAME: Christine Abril DATE: 2/27/04

SH-900.1 (2-03)

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

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: Operations - Distribution Center	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 520 Kingsland Avenue	AVERAGE NUMBER OF EMPLOYEES: 13
CITY, STATE, ZIP CODE: Brooklyn, NY 11222	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept. of Health + Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 21,800
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 ... If a category has no cases, enter "0."

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. [illegible]
DEATHS	0			INJURIES 0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H)	TRANSFER OR RESTRICTION	0 (Col. K)	SKIN DISORDERS 0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)	AWAY FROM WORK	0 (Col. L)	RESPIRATORY CONDITIONS 0 (Col. 3)
RECORD-ABLE CASES	0 (Col. J)			POISONINGS 0 (Col. 4)
				ALL OTHER ILLNESSES 0 (Col. 5)

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: Christine Abril TITLE: PAA

PRINT NAME: Christine Abril DATE: 2/27/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Operations - Administration / Timekeeping	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 Worth Street, Rm. 1012 & 1020	AVERAGE NUMBER OF EMPLOYEES: 15
CITY, STATE, ZIP CODE: New York, NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 26,250
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept of Health - Mental Hygiene	
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORDABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Christine Abril TITLE: PHA

PRINT NAME: Christine Abril DATE: 2/27/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Richmond Chest Clinic	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 51 Stuyvesant Place 4th Fl	AVERAGE NUMBER OF EMPLOYEES: 12
CITY, STATE, ZIP CODE: Staten Island, NY 10301	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 89,579
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Wanda Osborne TITLE: PAA

PRINT NAME: Wanda Osborne DATE: 12/30/03

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: ~~NYCDOHMH~~ HPDP — Bureau of Tobacco Control	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 2 Lafayette St. 21st FL.	AVERAGE NUMBER OF EMPLOYEES: 23
CITY, STATE, ZIP CODE: New York, NY 10007	
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: * 41,860
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS). ____ ____ ____ ____ ____ ____	* 1,820 hrs/yr X 23

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Ramlakhan TITLE: HQ Safety Compliance Inspector

PRINT NAME: INGRID RAMLAKHAN DATE: 1/30/04

SH-900.1 (2-03)

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

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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 City of New York, Health and Mental Hygiene, Bureau of Environmental Disease Prevention	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 253 Broadway, 11th floor, CN55	AVERAGE NUMBER OF EMPLOYEES 132
CITY, STATE, ZIP CODE New York, NY 10007	
INDUSTRY DESCRIPTION (e.g.,village fire department) City government	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 240,240
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	1 (Col.1)
DAYS AWAY FROM WORK	1 (Col. H)	AWAY FROM WORK	23 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Assistant Commissioner

PRINT NAME Jessica Leighton DATE 2/27/04

SH-900.1 (2-03)

Post until: 4-30-2004 DO NOT REMOVE

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

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: Bureau of TB Control - Central Office	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 225 Broadway, 22nd Floor	AVERAGE NUMBER OF EMPLOYEES: 90
CITY, STATE, ZIP CODE: New York, NY 10007	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 157,500
STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN.	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

6. CERTIFICATION

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

SIGNATURE: Ruth Wangerin — TITLE: Safety Compliance Officer

PRINT NAME: Ruth Wangerin — DATE: Feb 1, 2004

SH-900.1 (12-02)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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

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: DOHMH CALL CENTER	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 40 WORTH STREET, Room 1610	AVERAGE NUMBER OF EMPLOYEES: 47
CITY, STATE, ZIP CODE: NEW YORK, NY 10013	
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC HEALTH DEPARTMENT	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEA: 58,800 hours
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	2 (Col.1)
DAYS AWAY FROM WORK	5 (Col. H)	AWAY FROM WORK	12 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	3 (Col. 5)

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 Pamela L. Harmon TITLE Director

PRINT NAME Pamela L. Harmon DATE 1-28-04

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
Building 12. Room 158
Albany NY 12240

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

All establishments covered by Part 801 **must** complete this 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. EMPLOYENT INFORMATION
ESTABLISHMENT NAME NYC DOHMH Division of Fiscal and Strategic Management	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS Office of Grants Administration 125 Worth Street Room 623	AVERAGE NUMBER OF EMPLOYEES 6
CITY, STATE, ZIP CODE New York NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 10525
INDUSTRY DESCRIPTION (e.g.. village fire department) Department of Health and Mental Hygiene	
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 ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	0 (Col. K.)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (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 Judith Oaskin TITLE PAA

PRINT NAME Judith Oaskin DATE 2/20/04

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

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: Public Health Training & Injury Epidemiology	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 2 Lafayette Street – 20th Floor	AVERAGE NUMBER OF EMPLOYEES: 24
CITY, STATE, ZIP CODE: New York, NY 10007	
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 37500
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 9 5 6 2 3 1 1 0	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: [signature] TITLE: City Research Scientist

PRINT NAME: CALAINE HERMANS-HENRY DATE: 4/28/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Early Intervention - Queens	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 54-17 Junction Blvd - 2nd Fl.	AVERAGE NUMBER OF EMPLOYEES: 43
CITY, STATE, ZIP CODE: Corona NY 11368	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept. of Mental Health & Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 75,259
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 624110 561110 621330 ____	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Lorina Hooper TITLE Office Manager

PRINT NAME LORINA HOOPER DATE 1/28/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Public Health Library	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 455 1st Avenue - 12th floor	AVERAGE NUMBER OF EMPLOYEES: 10
CITY, STATE, ZIP CODE: New York, NY 10016	
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC-Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 9800
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 5 6 1 1	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: [signature] TITLE: City Research Scientist

PRINT NAME: CALAINE HEMANS-HENRY DATE: 4/28/04

SH-900.1 (2-03)

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

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Partial year only

1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: CNY Dept of Health and Mental Hygiene	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 40 North St	AVERAGE NUMBER OF EMPLOYEES: 39
CITY, STATE, ZIP CODE: Newburgh, NY 12553	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 24570
INDUSTRY DESCRIPTION (e.g., village fire department): OFFICE BUILDING	
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: None (Col. G)	JOB TRANSFER OR RESTRICTION: None (Col. K)	INJURIES: None (Col. 1)
DAYS AWAY FROM WORK: (Col. H)	AWAY FROM WORK: (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)
		ALL OTHER ILLNESSES: (Col. 5)

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: Charles A. Reiche TITLE: Health and Safety officer

PRINT NAME: Charles A. Reiche DATE: 01-21-04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME NYC DOHMH Bureau of Maternal, Infant & Reproductive Health Community Educational Service	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 25 Chapel St.	AVERAGE NUMBER OF EMPLOYEES 8
CITY, STATE, ZIP CODE Brooklyn, New York, 11201	
INDUSTRY DESCRIPTION (e.g., village fire department) Health department educational unit	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 13780
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 [signature] TITLE Dir, Comm Ed Services

PRINT NAME Yvonne Sinclair DATE 2/10/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME N.Y.C. DOH/MH Bureau of Maternal Infant & Reproductive Health	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 164-19 Hillside Ave	AVERAGE NUMBER OF EMPLOYEES 16
CITY, STATE, ZIP CODE Jamaica, N.Y. 11432	
INDUSTRY DESCRIPTION (e.g.,village fire department)	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 28,000
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	3 (Col.1)
DAYS AWAY FROM WORK	2 (Col. H)	AWAY FROM WORK	33 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	1 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 J Palmer TITLE (Acting) Site Administrator

PRINT NAME Joy Palmer. DATE 2/02/04

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
Building 12. Room 158
Albany NY 12240

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Business Systems Improvement City of New York Department of Health and Mental Hygiene	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 Worth Street, Room 627	AVERAGE NUMBER OF EMPLOYEES **8**
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) Municipal Health Department	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR **14,560**
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120	

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		10. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	**JOB TRANSFER OR RESTRICTION**	0 (Col. K.)	**INJURIES**	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H.)	**AWAY FROM WORK**	0 (Col. L.)	**SKIN DISORDERS**	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			**RESPIRATORY CONDITIONS**	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			**POISONINGS**	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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** Assistant Commissioner

PRINT NAME Charles Troob **DATE** February 10, 2004

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Management Information Services	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 Worth Street	AVERAGE NUMBER OF EMPLOYEES: 77
CITY, STATE, ZIP CODE: New York, NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 140,140
INDUSTRY DESCRIPTION (e.g.,village fire department)	
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Tamira Collins TITLE: Clerical Associate II

PRINT NAME: Tamira Collins DATE: 2/4/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME NYC DOHMH ASTORIA HEALTH CENTER /OPERATIONS	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 12-26 31st AVENUE	AVERAGE NUMBER OF EMPLOYEES 5
CITY, STATE, ZIP CODE ASTORIA, N.Y. 11106	
INDUSTRY DESCRIPTION (e.g.,village fire department) PUBLIC HEALTH CLINIC	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 7,360
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Kevin M. Heath TITLE HEALTH SERVICE MANAGER

PRINT NAME KEVIN McGRATH DATE 2/2/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME NYC DOHMH CORONA HEALTH CENTER / OPERATIONS	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 34-33 JUNCTION BOULEVARD	AVERAGE NUMBER OF EMPLOYEES 6
CITY, STATE, ZIP CODE JACKSON HEIGHTS, N.Y. 11372	
INDUSTRY DESCRIPTION (e.g.,village fire department) PUBLIC HEALTH CLINIC	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 9,647.5
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Kevin McGrath TITLE HEALTH SERVICE MANAGER

PRINT NAME KEVIN McGRATH DATE 2/2/04

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Divison of Safety and Health
Public Employee Safety and Health
State Office Campus
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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH-900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME NYC DOHMH JAMAICA HEALTH CENTER / OPERATIONS	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 90-37 PARSONS BOULEVARD	AVERAGE NUMBER OF EMPLOYEES 5
CITY, STATE, ZIP CODE JAMAICA, N.Y. 11432	
INDUSTRY DESCRIPTION (e.g.,village fire department) PUBLIC HEALTH CLINIC	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 6,954
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	6 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Kevin Mc Grath TITLE HEALTH SERVICE MANAGER

PRINT NAME KEVIN Mc GRATH DATE 2/2/04

SH-900.1 (2-03)

STATE OF NEW YORK
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Divison of Safety and Health
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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME NYC DOHMH LOWER MANHATTAN HEALTH CENTER/OPERATIONS	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 303 NINTH AVENUE	AVERAGE NUMBER OF EMPLOYEES 5
CITY, STATE, ZIP CODE NEW YORK, N.Y. 10001	
INDUSTRY DESCRIPTION (e.g.,village fire department) PUBLIC HEALTH CLINIC	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 9,446.5
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Kevin M Heath TITLE HEALTH SERVICES MANAGER

PRINT NAME KEVIN McGRATH DATE 2/2/04

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Divison of Safety and Health
Public Employee Safety and Health
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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH-900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME Office of chief Medical Examiner	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS * 520 First Avenue	AVERAGE NUMBER OF EMPLOYEES 435
CITY, STATE, ZIP CODE Manhattan, NY. 10016	
INDUSTRY DESCRIPTION (e.g., village fire department) Medical Examiner - Health	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 684,892
STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN, ____ ____ ____ ____	

* 5 boro sites - 451 Clarkson Ave, Bklyn, 460 Brille Ave, SI, 520 1st Ave, Mn 8268 - 164 St, Qns, 1 East Bldg #5 Pelham Pkway Bx,

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)	JOB TRANSFER OR RESTRICTION	— (Col. K)	INJURIES	7 (Col. 1)
DAYS AWAY FROM WORK	— (Col. H)	AWAY FROM WORK	69 (Col. L)	SKIN DISORDERS	— (Col. 2)
JOB TRANSFER OR RESTRICTION	— (Col. I)			RESPIRATORY CONDITIONS	— (Col. 3)
OTHER RECORDABLE CASES	— (Col. J.)			POISONINGS	— (Col. 4)
				ALL OTHER ILLNESSES	— (Col. 5)

6. CERTIFICATION

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

SIGNATURE Kos TITLE Dir. of Health and safety

PRINT NAME Kosiborod DATE 01.22.04

SH-900.1 (12-02)

Fax: Feb 23 2004 09:49 P.02

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

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 New York City Department of Health and Mental Hygiene- Public Health Laboratories	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 455 First Avenue	AVERAGE NUMBER OF EMPLOYEES 203
CITY, STATE, ZIP CODE New York, NY 10016	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 360,070
INDUSTRY DESCRIPTION (e.g.,village fire department) laboratories	
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	7 (Col.1)
DAYS AWAY FROM WORK	16 (Col. H)	AWAY FROM WORK	36 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	5 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	4 (Col. 5)

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 Diana Wysocki TITLE Community Coordinator

PRINT NAME Diana Wysocki DATE February 5, 2004

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: City of N.Y. Dept of Health and Mental Hygiene	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 155 E. 115 Street	AVERAGE NUMBER OF EMPLOYEES: 17
CITY, STATE, ZIP CODE: New York, New York 10029	
INDUSTRY DESCRIPTION (e.g., village fire department): DOHMH DISTRICT OFFICE BUILDING	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 14,994
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
None	None	
DEATHS _____ (Col. G)	JOB TRANSFER OR RESTRICTION _____ (Col. K)	INJURIES None _____ (Col.1)
DAYS AWAY FROM WORK _____ (Col. H)	AWAY FROM WORK _____ (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)
		ALL OTHER ILLNESSES _____ (Col. 5)

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 Charles A. Reiche TITLE Health & Safety Officer

PRINT NAME Charles A. Reiche DATE 01-21-04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: City Dept of Health + Mental Hygiene	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 1826 Arthur Avenue	AVERAGE NUMBER OF EMPLOYEES: 20
CITY, STATE, ZIP CODE: Bronx, N.Y. 10457	
INDUSTRY DESCRIPTION (e.g.,village fire department): Building	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 45,120
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: None (Col. G)	None	INJURIES: None (Col.1)
DAYS AWAY FROM WORK: (Col. H)	JOB TRANSFER OR RESTRICTION: (Col. K)	SKIN DISORDERS: (Col. 2)
JOB TRANSFER OR RESTRICTION: (Col. I)	AWAY FROM WORK: (Col. L)	RESPIRATORY CONDITIONS: (Col. 3)
OTHER RECORD-ABLE CASES: (Col. J.)		POISONINGS: (Col. 4)
		ALL OTHER ILLNESSES: (Col. 5)

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: Charles A. Reiche TITLE: Health + Safety Officer

PRINT NAME: Charles A Reiche DATE: 01/26/04

SH-900.1 (2-03)

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

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

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1. ESTABLISHMENT INFORMATION Bushwick	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME C. N.Y. Dept of Health and Mental Hygiene	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 335 Central Avenue Brooklyn, NY 11221	AVERAGE NUMBER OF EMPLOYEES 16
CITY, STATE, ZIP CODE Building	
INDUSTRY DESCRIPTION (e.g.,village fire department)	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 18144
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)	JOB TRANSFER OR RESTRICTION	(Col. K)	INJURIES	1 (Col.1)
DAYS AWAY FROM WORK	1 (Col. H)	AWAY FROM WORK	25 (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)
				ALL OTHER ILLNESSES	(Col. 5)

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 Charles A. Reiche TITLE ~~Health and Safety Officer~~

PRINT NAME Charles A. Reiche DATE 02 - 20 - 04

SH-900.1 (2-03)

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

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location
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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: C.N.Y. / Dept. of Health and Hospital (Hygiene)

STREET ADDRESS: 1655 Fulton Street

CITY, STATE, ZIP CODE: Brooklyn, NY 11233

INDUSTRY DESCRIPTION (e.g., village fire department): Building

NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS):

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES: 10

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 3480

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

DEATHS: None (Col. G)

DAYS AWAY FROM WORK: (Col. H)

JOB TRANSFER OR RESTRICTION: (Col. I)

OTHER RECORDABLE CASES: (Col. J.)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION: None (Col. K)

AWAY FROM WORK: (Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES: None (Col.1)

SKIN DISORDERS: (Col. 2)

RESPIRATORY CONDITIONS: (Col. 3)

POISONINGS: (Col. 4)

ALL OTHER ILLNESSES: (Col. 5)

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: Charles A. Reiche TITLE: Health + Safety Officer

PRINT NAME: Charles A. Reiche DATE: 01-21-04

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Communications / Community Relations.	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 Worth street, Room	AVERAGE NUMBER OF EMPLOYEES: 06
CITY, STATE, ZIP CODE: New York, NY 10013	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Department of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 10500
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Olivia Mera TITLE PMO

PRINT NAME OLIVIA MERA DATE 3/2/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Communications / Press Office and Program Mgt. Officer.	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 Worth Street, Room 329 & 348	AVERAGE NUMBER OF EMPLOYEES: 10
CITY, STATE, ZIP CODE: New York, NY 10013	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Department of Health and Mental Hygiene.	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 17500
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: [signature] TITLE: PMO

PRINT NAME: OLIVIA MERA DATE: 3/2/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Communications / Cross-Cultural Communication	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 Worth Street, Room 342	AVERAGE NUMBER OF EMPLOYEES: 3
CITY, STATE, ZIP CODE: New York, NY 10013	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Department of Health and Mental Hygiene.	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 3570
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	1 (Col.1)
DAYS AWAY FROM WORK	1 (Col. H)	AWAY FROM WORK	240 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 [signature] TITLE PHO

PRINT NAME OLIVIA MERA DATE 03/2/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Communications / Health Media & Marketing Online Editing	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 Worth Street, Room 342-339	AVERAGE NUMBER OF EMPLOYEES: 13
CITY, STATE, ZIP CODE: New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Department of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 22 750
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	(Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 PHG

PRINT NAME OLIVIA MERA DATE 3/2/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Environmental Health, Admin. Office	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 Worth Street, Rm. 616 + Rm. 613	AVERAGE NUMBER OF EMPLOYEES: 14
CITY, STATE, ZIP CODE: New York, N.Y. 10013	
INDUSTRY DESCRIPTION (e.g.,village fire department): NYC Dept. of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 23,407
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 9 2 3 1 2 0 / 5 6 1 1	

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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Meredith Laureno — TITLE: PAA level I

PRINT NAME: Meredith Laureno — DATE: March 15, 2004

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: NYC DOHMH STD Control	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 125 WORTH ST BOX 73	AVERAGE NUMBER OF EMPLOYEES: 235
CITY, STATE, ZIP CODE: New York, N.Y. 10013	
INDUSTRY DESCRIPTION (e.g., village fire department): Diagnostic + Treatment Centers	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 394,800
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	18 (Col. 1)
DAYS AWAY FROM WORK	394 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	8 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	8 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 Linda Brown TITLE Program Planner

PRINT NAME Linda BROWN DATE 1/23/04

SH-900.1 (2-03)

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: DOHMH	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 1075 Ralph Avenue	AVERAGE NUMBER OF EMPLOYEES: _____
CITY, STATE, ZIP CODE: Bklyn, NY. 11212	
INDUSTRY DESCRIPTION (e.g.,village fire department): Pest Control	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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	2 (Col.1)
DAYS AWAY FROM WORK	2 (Col. H)	AWAY FROM WORK	36 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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 _____

NEW YORK
NT 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

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: ORAL HEALTH, PROGRAMS & POLICY REGION II	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 600 W. 168 ST 1st FL.	AVERAGE NUMBER OF EMPLOYEES: 3
CITY, STATE, ZIP CODE: N.Y., NY 10032	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC DOHMH	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 4750
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	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. K)	INJURIES	0 (Col.1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. L)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. 5)

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: Mark Lewis TITLE: Regional Director

PRINT NAME: MARK LEWIS DATE: 1-29-04

SH-900.1 (2-03)

OF NEW YORK
TMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
Building 12. Room 158
Albany NY 12240

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME ORAL HEALTH PROGRAMS & POLICY - REGION 1	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 1932 ARTHUR AVE RM 403B	AVERAGE NUMBER OF EMPLOYEES 24
CITY, STATE, ZIP CODE BRONX, NY 10457	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 36,340
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC DOHMH	
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 ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	0 (Col. K.)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (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 Mark Lewis TITLE Regional Director

PRINT NAME MARK LEWIN DATE 1-29-04

SH 900.1 (12-03)

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

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

ESTABLISHMENT NAME: NYC Dept of Health + Mental Hygiene

STREET ADDRESS: 66 John St, 11th Fl

CITY, STATE, ZIP CODE: NY NY 10038

INDUSTRY DESCRIPTION (e.g.,village fire department): Municipal Gov't Agency

STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN.

2. EMPLOYMENT INFORMATION

If you don't have accurate figures, see the instructions on the back of this sheet.

AVERAGE NUMBER OF EMPLOYEES: 43

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 81,000

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

DEATHS	0 (Col. G)
DAYS AWAY FROM WORK	0 (Col. H)
JOB TRANSFER OR RESTRICTION	0 (Col. I)
OTHER RECORDABLE CASES	0 (Col. J.)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0 (Col. K)
AWAY FROM WORK	1/2 (Col. L)

5. INJURIES AND ILLNESS TYPES

INJURIES	1 (Col. 1)
SKIN DISORDERS	0 (Col. 2)
RESPIRATORY CONDITIONS	0 (Col. 3)
POISONINGS	0 (Col. 4)
ALL OTHER ILLNESSES	0 (Col. 5)

6. CERTIFICATION

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

SIGNATURE: Charles P. Miller — TITLE: Asst. Dir. of Tribunal Ops.

PRINT NAME: Charles P. Miller — DATE: January 30, 2004