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SH-900.1 (2-03)	PRINT NAME NONIE GILLESPIE DATE	I certify that I have examined this document and that to the best of my knowledge the entries are true, SIGNATURE DIVE ULLED PA	6. CERTIFICATION	JOB TRANSFER OR RESTRICTION OTHER RECORD- ABLE CASES (Col. J.) (Col. J.) (Col. L)	Col. G) DAYS AWAY FROM WORK (Col. H) (Col. H) (Col. K)		3. NUMBER OF CASES	Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each category (column labels under correspond to the columns on the Log). If a category has no cases, enter "0."	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).	CHEST CENTER	BRUCKLYN NY 11212.		BROWNSVILLE CHEST CENTER STREET ADDRESS	1. ESTABLISHMENT INFORMATION	All establishments covered by PART 801 <u>must</u> 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 equivate 801.35 and instructions for further details on access provisions for these forms.	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH-900.1	DEPARTMENT OF LABOR
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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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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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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.

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DEPARTMENT OF LABOR

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.

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ED	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
State Office Campus Building 12, Room 158 Albany NY 12240		- - -
Division of Safety and Health Public Employee Safety and Health Burgary		DEPARTMENT OF LABOR

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14 /		AVERAGE NUMBER OF EMPLOYEES
BRODILLYN, N	14,11203	44
DEPARTMENT Of HEALTH and MENTAL HE	ise fire department) In aud Mental Hydieine	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
(NAICS) 623290	CLASSIFICATION SYSTEMV	67600
Enter the column totals from the Log of Occupational Injuries and Illnesses correspond to the columns on the Log). If a category has no cases, enter "0"	f Occupational Injuries and Illnesses (SH 90) If a category has no cases, enter "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 ILLNESSES TYPES
DEATHS		INJURIES
ORK	AWAY FROM 2/ WORK (Col. K.)	SKON DISORDERS
JOB TRANSFER (Col. H.) OR RESTRUCTION	JOB TRANSFER OR	RESPIRATORY CONDITIONS
ABLE CASES	(Col. L.)	POISONINGS
(Col. J.)		HEARING LOSS
		ALL OTHER ILLNESSES (Col. 5)
	6. CERTIFICATION	
I certify that I have examined the	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and contract \mathcal{R} is the formula of \mathcal{R} is the form	Ise the entries are true, accurate, and complete.
PRINT NAME NGIL KCS	csiborod	01.25.06
5H 900.I (12-03)		



Division of Safery and Health Public Employce Safery 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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T certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. TRE TITLE AME DATE	his document and that to the best of my knowld	SIGNATURE PRINT NAME
	6. CERTIFICATION	
HEARING LOSS		(Col. J.)
RESPIRATORY CONDITIONS	JOB TRANSFER OR D RESTRICTION (Col. L.)	OR RESTRUCTION (Cal. I.) OR RESTRUCTION (Cal. I.) OTHER RECORD-
SKIN DISORDERS	AWAY FROM O WORK (Col. K.)	DEATHS (Col. G) DAYS AWAY FROM WORK
5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	AVOLING 10314 age fire department) the and MENtal Hygiene CLASSIFICATION SYSTEM	INDUSTRY DESCRIPTION (e.g., village fire department) DEPAREMENT of HEALTY and MENTAL H. NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 623990
AVERAGE NUMBER OF EMPLOYEES	thally	ODE
If you don't have acclimate figures, see the Instructions on the back of the sheet.	Evenine Avenue	ESTABLISHMENTNAME 0741 MEDICUL 5 STREET ADDRESS 460 - B
2. EMPLOYENT INFORMATION	T INFORMATION	1. ESTABLISHMENT INFORMATION
All establishments covered by Part 801 <u>must</u> complete this annually, even if no occupational injuries or illnesses occurred during the year. Employees, formet 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.	All establishments covered by Part 801 <u>must</u> complete this annually, even if no occupational injur Employees, formet employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	All establishments covered by Part 801 n Employees, former employees, and their its equivalent. See 801.35 and instruction
ED	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
Division of Safery and Health Public Employee Safery and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240		STATE OF NEW YORK DEPARTMENT OF LABOR

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SH 900.1 (12-03)

		SH 900.1 (12-03)
DATE 1/20/05	2 BROWNE	SIGNATURE PRINT NAME OSWAL
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	6. CERTIFICATION	
ALL OTHER ILLNESSES $(Col.5)$		
POISONINGS O	6	$\begin{array}{c} \text{(Col. I.)} \\ \text{ABLE CASES} \\ \hline \\ $
RESPIRATORY CONDITIONS O	JOB TRANSFER OR	JOB TRANSFER O (Col. 11.) OR RESTRICTION O
SKIN DISORDERS (Col. 2)	AWAY FROM O WORK (Col. K.)	Col. G.)
INJURIES O		DEATHS Ø
5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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".	f Occupational Injuries and Illnesses (SH 900 If a category has no cases, enter "0".	Enter the column totals from the Log of correspond to the columns on the Log).
01305	19, 561710	(NAICS) 923120, 621399
HUGLENE TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	-	L DEPT OF
32	11236	BROKYN N.S
AVERAGE NUMBER OF EMPLOYEES	NE	ATHA 4
If you don't have accurate figures, see the Instructions on the back of the sheet.	SERVICES BROOKLYN South	CONTROL SERVICE
2. EMPLOYENT INFORMATION		SI
Employees, former employees, and their representatives have the right to review this form. They also have limited access to the Log (S11-900) or its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	Employees, former employees, and their its equivalent. See 801.35 and instruction
All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during the year.	<u>tust</u> complete this annually, even if no occupati	All establishments covered by Part 801 \underline{n}

Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240 2005

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

		SH OND I (12 M2)
DATE 1/20/3000	Dayne	PRINT NAME Della Pa
TITLE Kessearch Assistant	pr.S	SIGNATURE JECCO (CL
edge the entries are true, accurate, and complete.	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and	I certify that I have examined.
	6. CERTIFICATION	
(Cal. 6)		
ALL OTHER ILLNESSES		
HEARING LOSS 0		(Col. J.)
POISONINGS 0 (Col. 4)	(Col. L.)	ABLE CASES 0
RESPIRATORY CONDITIONS 0 (Col. 3)	JOB TRANSFER OR RESTRICTION 0	JOB TRANSFER OR RESTRICTION 0
SKIN DISORDERS 0 (Col. 2)	AWAY FROM 4 WORK (Col. K.)	FROM WORK (Col. G.)
INJURIES 1 (Col. 1)		DEATHS 0
5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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12,420	$\frac{1}{2} = \frac{1}{2}$	(NAICS) 9 2 3 1 2 0
TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	ige fire department) alth and Mental Hygiene	New York City Department of Health and Mental Hygiene
4		New York, NY 10013
AVERAGE NUMBER OF EMPLOYEES		125 Worth Street, Room #619 CITY, STATE, ZIP CODE
If you don't have accurate figures, see the Instructions on the back of the sheet.	ices - Central Office	Veterinary and Pest Control Services - STREET ADDRESS
2. EMPLOYENT INFORMATION	ESTABLISHMENT INFORMATION	1. ESTABLISHMEN
rm. They also have limited access to the Log (SH-900) or hese forms.	Employees, former employees, and their representatives have the right to review this form. They also have limited access to its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	Employees, former employees, and their its equivalent. See 801.35 and instruction
All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during the year.	nust complete this annually, even if no occupa	All establishments covered by Part 801

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2005

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

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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

2005

RESPIRATORY CONDITIONS	WORK (Col. K) JOB TRANSFER OR RESTRICTION (Col. L.)	DAYS AWAY FROM WORK JOB TRANSFER OR RESTRICTION OTHER RECORD-	
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5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES	
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40		New York N.Y. 1	
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All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during the year.	ust complete this annually, even if no occupati	All establishments covered by Part 801 m	

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HEARING LOSS

ALL OTHER ILLNESSES

(Col. J.)

	INJURIES AND ILLNESSES FORM SH 900.1	2005
All establishments covered by Part 801 m	ust complete this annually, even if no occupation	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 r its equivalent. See 801.35 and instruction	Employees, former employees, and their representatives have the right to review this form. They also have limited access to the its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	n. They also have limited access to the Log (SH-900) or ese forms.
1. ESTABLISHMENT INFORMATION	r information	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Burlow	and of TB Control	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 51 Struwesant Place 4th floor		
CITY, STATE, ZIP CODE		AVERAGE NUMBER OF EMPLOYEES
Staten Island, New York 10301		J.
TRY		TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
Clinic NYC Dept o	tal thygic	ne .
(NAICS) (2012 0 0 0 2 10 0	2 VO D	26,390.
	1 1	
correspond to the columns on the Log.	If a category has no cases, enter "0".	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
>	-	INJURIES 0 (Col. 1)
DEATHS (Col. G.) DAYS AWAY (Col. G.)	AWAY FROM 0 WORK (Col. K.)	SKIN DISORDERS 0 (Col. 2)
(Col	JOB TRANSFER OR	RESPIRATORY CONDITIONS 0 (Col. 3)
ORD-	RESTRICTION (Col. L.)	POISONINGS (Col. 4)
ABLE CASES (Col. J.)		HEARING LOSS 0
		ALL OTHER ILLNESSES (Col. 5)
	6. CERTIFICATION	
I certify that I have examined	this document and that to the best of my knowle	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.
PRINT NAME Wanda Osborne		DATE 1/3/06
SH 900.1 (12-03)		

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES

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

	0	
3. NUMBER OF CASES	4. NUMBER OF DAYS	5. INJURIES AND ILLNESSES TYPES
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OTHER RECORD- ART & CASES 0	(Col. L.)	POISONINGS (Col. 4)
(Col. J.)		HEARING LOSS 0
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	6. CERTIFICATION	
I certify that I have examined t	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.	Ige the entries are true, accurate, and complete. TITLE Principal Administrative Associate
PRINT NAME Wanda Osborne		DATE
SH 900.1 (12-03)		14 8

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".

(NAICS) Clinic INDUSTRY DESCRIPTION (e.g., village fire department) STREET ADDRESS NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM Bronx, New York 10456 CITY, STATE, ZIP CODE ESTABLISHMENT NAME 1309 Fulton Avenue, 1st floor Morrisania Chest Center 190 923 1201 Dept 00 627399 BUREAU Hea. Hhe OF e Mentai Ē CONTROL Hogiene TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR If you don't have accurate figures, see the AVERAGE NUMBER OF EMPLOYEES Instructions on the back of the sheet. 6 50

STATE OF NEW YORK DEPARTMENT OF LABOR



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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES

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All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during the year. **FORM SH 900.1**

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

FORM SH 900.1 FORM SH 900.1 FORM SH 900.1 FORM SH 900.1 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 801.33 and instructions for further details on access provisions for these forms. I. ESTABLISHMENT INFORMATION ESTABLISHMENT INFORMATION I. ESTABLISHMENT INFORMATION IF addition access provisions for these forms. If you don't have accurate figures, see the Instructions on the back of the sheet. ISTENT J. PG CRUPT INFORMATION ALP of VL AP J. MUMBER OF CASES INFORMETION Systepsile AP	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 <u>G. G. J. C. J. TITLE</u> <u>Research</u> <u>Assistant</u> PRINT NAME <u>G. C. T. C. D. D. T. 1/25/06</u>
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	IHS O INJURIES SAWAY (Col. G.) AWAY FROM O SAWAY O AWAY FROM O SAWAY O WORK (Col. K.) TRANSFER O JOB TRANSFER OR O ER RECORD- O RESTRICTION O Col. J. INJURIES AWAY FROM O ER RECORD- O JOB TRANSFER OR O Col. J. RESTRICTION INJURIES POISONINGS ER RECORD- O RESTRICTION AWAY FROM O Col. J. JOB TRANSFER OR O POISONINGS HEARING LOSS E CASES Col. J. HEARING LOSS ALL OTHER ILLNESSES HEARING LOSS
O INJURIES	

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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

SH 900.1 (12-03)	I certify that I have examined thi SIGNATURE		DEATHS (Col. G.) DAYS AWAY FROM WORK (Col. H.) JOB TRANSFER OR RESTRICTION (Col. H.) OTHER RECORD- ABLE CASES (Col. J.)	3. NUMBER OF CASES	Enter the column totals from the Log of Oc correspond to the columns on the Log). If	125 WATE, ZIP CODE CITY, STATE, ZIP CODE NEW YAL NY 10013 CN 6 INDUSTRY DESCRIPTION (e.g., village fire department) NY C DLON of He, OH Mental NORTH AMERICANINDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399
	s document and that to the best of my know	6. CERTIFICATION	AWAY FROM WORK (Col. K.) JOB TRANSFER OR (Col. L.)	4. NUMBER OF DAYS	cupational Injuries and Illnesses (SH 900 a category has no cases, enter "0".	N 6 Neutal Hygiene System Jugiene
	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. JRE $\int checker = \frac{1}{24} + \frac{1}{24$		SKIN DISORDERS SKIN DISORDERS RESPIRATORY CONDITIONS POISONINGS HEARING LOSS ALL OTHER ILLNESSES (Col. 5) (Col. 5) (Col. 5) (Col. 6)	5. INJURIES AND ILLNESSES TYPES	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".	AVERAGE NUMBER OF EMPLOYEES $\frac{\sqrt{2}}{\sqrt{2}}$ TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR $\frac{\sqrt{2}}{\sqrt{2}}$



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

2005

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.

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ESTABLISHMENT NAME

1. ESTABLISHMENT INFORMATION Division

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2. EMPLOYENT INFORMATION

Instructions on the back of the sheet.

	Vedge the entries are true, accurate, and complete.	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, JRE <u>Ulena</u> , <u>Athluwaba</u> on <u>behalf of Lynn Silv</u> epTITLE <u>Assistant Comming</u> AME Dr. Lynn Silver <u>DATE</u> <u>1/24/2005</u>	I certify that I have examined SIGNATURE <u>Aleena</u> , <u>Aleena</u> PRINT NAME Dr. Lynn Silver
1		6. CERTIFICATION	
I	HEARING LOSS 0 ALL OTHER ILLNESSES 0(Col. 5) (Col. 6)		(Col. J.)
	POISONINGS (Col. 4)	(Col. L.)	DRD-
	RESPIRATORY CONDITIONS (Col. 3)	JOB TRANSFER OR 0	
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	INJURIES 0 (Col. 1)		0
L	5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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".	Occupational Injuries and Illnesses (SH 900 If a category has no cases, enter "0".	Enter the column totals from the Log o correspond to the columns on the Log).
L			923120, 621399
	approx. 92645 hrs	LASSIFICATION SYSTEM	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM
	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR		INDUSTRY DESCRIPTION (e.g., village fire department) NYC Department of Health & Mental Hygiene
	56		New York, NY 10007
-			CITV CTATE 710 CODE



Public Employee Safety and Health Bureau State Office Campus Division of Safety and Health

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.

STREET ADDRESS

2 Lafayette Street, 20th Floor

ESTABLISHMENT NAME

1. ESTABLISHMENT INFORMATION

If you don't have accurate figures, see the

2. EMPLOYENT INFORMATION

Instructions on the back of the sheet.

AVERAGE NUMBER OF EMPLOYEES

Bur. of Chronic Disease Prevention & Control

Building 12. Room 158 Albany NY 12240

2005

SH 900.1 (12-03)

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SH 900.1 (12-03)	I certify that I have examined SIGNATURE PRINT NAME PRINT NAME		DEATHS DAYS AWAY FROM WORK JOB TRANSFER OR RESTRICTION OTHER RECORD- ABLE CASES (Col. I.) (Col. I.) (Col. J.)	3. NUMBER OF CASES		STATE OF NEW YORK DEPARTMENT OF LABOR
ł	this document and that to the best of my know	6. CERTIFICATION	AWAY FROM WORK (Col. K.) JOB TRANSFER OR RESTRICTION (Col. L.)	4. NUMBER OF DAYS	Albany NY 12240 SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1 All establishments covered by Part 801 <u>must</u> complete this annually, even if no occupational injuries or illnesses occur its equivalent. See 801.35 and instructions for further details on access provisions for these forms. Injuries of the representatives have the right to review this form. They also have limited acc its equivalent. See 801.35 and instructions for further details on access provisions for these forms. Integration I. ESTABLISHMENT INFORMATION I. ESTABLISHMENT INFORMATION I. ENPLOYENT INFORMATION I. ESTABLISHMENT INFORMATION If you don't have accurs INDUSTRY DESCRIPTION (e.g., village file@epirtment) If you don't have accurs INDUSTRY DESCRIPTION (e.g., village file@epirtment) If you don't have accurs INDUSTRY DESCRIPTION (e.g., village file@epirtment) If you don't have accurs INDUSTRY DESCRIPTION (e.g., village file@epirtment) If you don't have accurs INDUSTRY DESCRIPTION (e.g., village file@epirtment) If you don't have accurs INDUSTRY DESCRIPTION (e.g., village file@epirtment) If you don't have accurs INDUSTRY DESCRIPTION (e.g., village file@epirtment) If you don't have accurs INDUSTRY DESCRIPTION (e.g., village file@epirtment) If you don't hours workeed by ALL INDUSTRY DESCRIPTION (e.g., village file@epirtment) I	
	RE MAR TITLE TARE <		INJURIES (Col. 1) SKIN DISORDERS (Col. 1) RESPIRATORY CONDITIONS (Col. 2) POISONINGS (Col. 3) POISONINGS (Col. 4) HEARING LOSS (Col. 4) HEARING LOSS (Col. 5) ALL OTHER ILLNESSES (Col. 6)	5. INJURIES AND ILLNESSES TYPES	Albany NY 12240 SUMMARY OF WORK-RELATED INURIES AND ILLNESSES FORM SH 90.1 205 All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during the year. 2065 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 INTERE ADDREES Jan T.A.C., HEALTH, JAC, T.J., Jac, M.J., Jac, T.J., Jac, M.J., M.J., K.F., M.K., M.K.E., M.K., M.K.E., M.K.E	Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158

I certify that I have examined this docun SIGNATURE OR Coul a klaan PRINT NAME Ingrid Ramlakhan		DEATHS0DAYS AWAY FROM WORK(Col. G.)JOB TRANSFER OR RESTRICTION(Col. H.)OTHER RECORD- ABLE CASES000(Col. J.)0	3. NUMBER OF CASES
I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. JRE JRE TITLE Health & Safety Compliance I AME Ingrid Ramlakhan DATE 1/31/06	6. CERTIFICATION	AWAY FROM 0 WORK (Col. K.) JOB TRANSFER OR RESTRICTION 0 (Col. L.)	4. NUMBER OF DAYS
In the entries are true, accurate, and complete. TITLE Health & Safety Compliance Inspector DATE		INJURIES SKIN DISORDERS RESPIRATORY CONDITIONS POISONINGS HEARING LOSS ALL OTHER ILLNESSES	5. INJURIES AND ILLNESSES
omplete. oliance Inspector		$\begin{array}{c} 0 \\ (Col. 1) \\ 0 \\ (Col. 2) \\ \hline (Col. 3) \\ \hline (Col. 4) \\ 0 \\ \hline (Col. 5) \\ \hline (Col. 6) \\ \end{array}$	TYPES

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".

123,260	(NAICS) 541612, 561110
	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM
TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	New York City Department of Health & Mental Hygiene
1	INDUSTRY DESCRIPTION (e.g., village fire department)
72	New York, NY 10013
	CITY, STATE, ZIP CODE
AVERAGE NUMBER OF EMPLOYEES	125 Worth St-Rms 900-916, 346 B'way-Rm 714, 49-51 Chambers St R M 72 AVERAGE NUMBER OF EMPLOYEES
	STREET ADDRESS
Instructions on the back of the sheet.	Bureau of Human Resources-(All Central Units)
If you don't have accurate figures, see the	ESTABLISHMENT NAME

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

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

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

2005

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

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	PRINT NAME Ingrid Ramlakhan	I certify that I have examined this docum SIGNATURE			(Col. J.)	OTHER RECORD- ARLE CASES 0	JOB TRANSFER (Col. H.)	Col. C.) DAYS AWAY FROM WORK 0	DEATHS 0	3. NUMBER OF CASES
		this document and that to the best of my knowle	6. CERTIFICATION			(Col. L.)	JOB TRANSFER OR	AWAY FROM 0 WORK (Col. K.)		4. NUMBER OF DAYS
	DATE 1/31/06	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. URE URALIAL TTTLE Health & Safety Compliance Inspector		ALL OTHER ILLNESSES (Col. 5)	HEARING LOSS 0	POISONINGS (Col. 4)	RESPIRATORY CONDITIONS 0 (Col. 3)	SKIN DISORDERS 0 (Col. 2)	INJURIES <u>(Col. 1)</u>	5. INJURIES AND ILLNESSES TYPES

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".

0,000	(NAICS)
8 050	
	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM
	I New York City Department of Health & Mental Hyglene
TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	
	INDUSTRY DESCRIPTION (e.g., village fire department)
G	New York, NY 10013
	CIT, STATE, ZIL CODE
AVERAGE NUMBER OF EMPLOYEES	346 Broadway, Room 708
	STREET ADDRESS
Instructions on the back of the sheet.	Bureau of Human Resources-WEP Unit
If you don't have accurate figures, see the	ESTABLISHMENT NAME If
2. EMPLOYENT INFORMATION	I. ESTABLISHMENT INFORMATION

Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus

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

2005

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.

DEPARTMENT OF LABOR STATE OF NEW YORK Building 12. Room 158 Albany NY 12240

PRINT NAME Ingrid Ramlakhan	SIGNATURE URam Calla	I certify that I have examined t		DAYS AWAY (Col. G.) FROM WORK 0 JOB TRANSFER (Col. H.) OR RESTRICTION 0 OTHER RECORD- 0 ABLE CASES (Col. J.)
	kl ar	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.	6. CERTIFICATION	AWAY FROM 0 WORK (Col. K.) JOB TRANSFER OR RESTRICTION 0 (Col. L.)
DATE 1/31/06	TITLE Health & Safety Compliance Inspector	edge the entries are true, accurate, and c		SKIN DISORDERS RESPIRATORY CONDITIONS POISONINGS HEARING LOSS ALL OTHER ILLNESSES
	liance Inspector	complete.		$\begin{array}{c} 0 \\ (Col. 2) \\ \hline 0 \\ (Col. 3) \\ \hline 0 \\ (Col. 4) \\ \hline 0 \\ \hline (Col. 5) \\ \hline (Col. 6) \end{array}$

13,070	(NAICS) 621111 621399
10 070	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM
TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	New York City Department of Health & Mental Hygiene
	INDUSTRY DESCRIPTION (e.g., village fire department)
Q	New York, NY 10001
	CITY, STATE, ZIP CODE
AVERAGE NUMBER OF EMPLOYEES	303 Ninth Avenue, Room 137
	STREET ADDRESS
Instructions on the back of the sheet.	Bureau of Human Resources-Employee Health Program
If you don't have accurate figures, see the	ESTABLISHMENT NAME
2. EMPLOYENT INFORMATION	1. ESTABLISHMENT INFORMATION
orm. They also have limited access to the Log (SH-900) or these forms.	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.

correspond to the columns on the Log). If a category has no cases, enter "0".

DEATHS

0

3

NUMBER OF CASES

4

NUMBER OF DAYS

5. INJURIES AND ILLNESSES TYPES

INJURIES

(Col. 1) 0 Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240

STATE OF NEW YORK DEPARTMENT OF LABOR

2005

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES

FORM SH 900.1

3. NUMBER OF CASES	4. NUMBER OF DAYS	5. INJURIES AND ILLNESSES TYPES
DEATHS 0 DAYS AWAY (Col. G.)	AWAY FROM 0 WORK (Col. K.)	INJURIES 0 (Col. 1) SKIN DISORDERS 0 (Col. 2)
JOB TRANSFER 0	JOB TRANSFER OR	RESPIRATORY CONDITIONS 0 (Col. 3)
(Col. I.)	(Col. L.)	POISONINGS 0 (Col. 4)
(Col. J.)		HEARING LOSS (Col. 5)
		ALL OTHER ILLNESSES (0) (Col. 6)
	6. CERTIFICATION	
I certify that have examined this d	this document and that to the best of my know	I certify that have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.
PRINT NAME Roxanne Kewley	C	DATE 2/2/06

1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME	If you don't have accurate figures, see the
FSM, Bureau of Finance - Administration	Instructions on the back of the sheet.
STREET ADDRESS	
125 Worth Street, Rm 630	AVERAGE NUMBER OF EMPLOYEES
CITY, STATE, ZIP CODE	
New York, N.Y. 10013	43
INDUSTRY DESCRIPTION (e.g., village fire department)	
New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561110 5/1000	78561 Hours

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**

2005

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STATE OF NEW YORK DEPARTMENT OF LABOR

SH 900.1 (12-03)

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TITLE DIDONTOD of Ofer ATIONS	11 Dyr. d	SIGNATURE Chymony
I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.	this document and that to the best of my know	I certify that I have examined t
	6. CERTIFICATION	
ALL OTHER ILLNESSES (Col. 5)		
POISONINGS (Col. 4)	(Col. L.)	ABLE CASES
RESPIRATORY CONDITIONS (Col. 3)	JOB TRANSFER OR	JOB TRANSFER
SKIN DISORDERS (Col. 2)	AWAY FROM Col. K.)	DAYS AWAY (Col. G.)
INJURIES (Col. 1)		
5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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".	f Occupational Injuries and Illnesses (SH 9 If a category has no cases, enter "0".	Enter the column totals from the Log of correspond to the columns on the Log).
33,250		(NAICS) 923/20 - 54/990
TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	AMEDICAN INDUSTRIAL OF ASSTERIATION SECTEM	NYC DEPT. of HCA (The ANENTAL (149/C)
91	210013	New Pork NY
AVERAGE NUMBER OF EMPLOYEES	R-100, 300	195 WORTH SARET
If you don't have accurate figures, see the Instructions on the back of the sheet.	Emergence WANAgement	ESTABLISHMENT NAME BUREAU of Emergens STREET ADDRESS
2. EMPLOYENT INFORMATION	INFORMATION	1. ESTABLISHMENT INFORMATION

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.

STREET ADDRESS (NAICS) 923120 NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM 2 PN INDUSTRY DESCRIPTION (e.g., village fire department) Jamaica, NY 11433 CITY, STATE, ZIP CODE ESTABLISHMENT NAME 166-10 Archer Avenue, Section C01 Dept of Health & Mental 1. ESTABLISHMENT INFORMATION Bureau of Maternal, Infant & Reproductive Health ŧ. 624190 Hygien 0 0 Leens TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR If you don't have accurate figures, see the AVERAGE NUMBER OF EMPLOYEES Instructions on the back of the sheet. 2. EMPLOYENT INFORMATION 17,500 10

Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each category (column labels under each line

State Office Campus Building 12. Room 158 Division of Safety and Health

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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DEPARTMENT OF LABOR Public Employee Safety and Health Bureau Albany NY 12240

STATE OF NEW YORK

RE NOUSERT ATRANOE DATE 117/06	this document and that to the best of my know	I certify that I have examined SIGNATURE The back
	6. CERTIFICATION	
ALL OTHER ILLNESSES (Col. 6)		
HEARING LOSS		ABLE CASES (Col. J.)
POISONINGS (Col. 4)	RESTRICTION (Col. L.)	OR RESTRICTION (Col. I.)
RESPIRATORY CONDITIONS O (Col. 3)	JOB TRANSFER OR	JOB TRANSFER
SKIN DISORDERS (Col. 2)	AWAY FROM O WORK (Col. K.)	DEATHS (Col. C.)
INJURIES (Col. 1)		٥
5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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00) for each category (column labels under each line	Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each category (column	Enter the column totals from the Log o
474	SG1720	(NAICS) $923/20$
HYCHENE TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	1.000	NYC DEPT OF HEALTH & MENTAL
6	800	NEW YORK
AVERAGE NUMBER OF EMPLOYEES	NENUE BSMT	2238 FIFTH
ERATION Instructions on the back of the sheet.	BUREAUN OF-OPERAIN	ESTABLISHMENT NAME BUR CENTURD HAL
2. EMPLOYENT INFORMATION	INFORMATION	1. ESTABLISHMENT INFORMATION
rm. They also have limited access to the Log (50-2007) of hese forms.	Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms	Employees, former employees, and their r its equivalent. See 801.35 and instruction
	<u>ust</u> complete this annually, even if no occupation of the second s	All establishments covered by Part 801 m
ED 2005	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240		STATE OF NEW YORK DEPARTMENT OF LABOR

SH 900.1 (12-03)

	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	2005 ·
All establishments covered by Part 801 n	nust complete this annually, even if no occupat	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 its equivalent. See 801.35 and instruction	Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	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	T INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT, NAME Health	1 Health Programs and Policy	If you don't have accurate figures, see the Instructions on the back of the sheet.
299 Droadary	Saite 500	AVERAGE NUMBER OF EMPLOYEES
\mathcal{N} CITY, STATE, ZIP CODE \mathcal{N}	0007	25
WOUSTRY DESCRIPTION (e.g., village fire department)	The Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
INN INDU	CLASSIFICATION SYSTEM	45.675
Enter the column totals from the Log of Occupational Injuries and Illnesses, correspond to the columns on the Log). If a category has no cases, enter "0"	of Occupational Injuries and Illnesses (SH 90 . If a category has no cases, enter "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 ILLNESSES TYPES
DEATHS DEATHS	AWAY FROM D	INJURIES (Col. 1) SKIN DISORDERS (Col. 7)
PROM WORK (Col. H.) JOB TRANSFER (Col. H.) OR RESTRICTION (Col. H.)	JOB TRANSFER OR U	RESPIRATORY CONDITIONS (Col. 3)
OTHER RECORD- ABLE CASES ∅	(Col. L.)	POISONINGS (Col. 4)
(cot. 13)		ALL OTHER ILLNESSES
	6. CERTIFICATION	
I certify that I have examined	this document and that to the best of my know $\mathcal{L}_{\mathcal{U}_{1}}^{(i)}$	I certify that have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.
PRINT NAME JAMES	WELL	1/31/26
SH 900.1 (12-03)		

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STATE OF NEW YORK DEPARTMENT OF LABOR

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

2005

I certify that I have examined this document and that to the best of m SIGNATURE <u>USA KANNE</u> MACANE		3. NUMBER OF CASES DEATHS O DAYS AWAY FROM WORK (Col. G.) JOB TRANSFER OR RESTRICTION (Col. H.) OTHER RECORD- ABLE CASES (Col. J.)	Enter the column totals from the Log of Occupational Injuries and Illnesses (correspond to the columns on the Log). If a category has no cases, enter "0".
ris document and that to the best of my knowl	6. CERTIFICATION	4. NUMBER OF DAYS AWAY FROM <u>5 0</u> WORK <u>(Col. K.)</u> JOB TRANSFER OR RESTRICTION <u>(Col. L.)</u>	Occupational Injuries and Illnesses (SH 90 If a category has no cases, enter "0".
I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. JRE <u>USALA MACA MACA TITLE Kalth Since Market Ma</u>		5. INJURIES AND ILLNESSES TYPES INJURIES 0 INJURIES (Col. 1) SKIN DISORDERS (Col. 2) RESPIRATORY CONDITIONS 0 POISONINGS 0 HEARING LOSS (Col. 5) ALL OTHER ILLNESSES (Col. 6)	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".

LISHMENT INFORMATION 2. EMP E. BUREAU DE OPERATUNS Troudon' E. MEAU ELEM DE OPERATUNS Troudon' LEM HEALTE CENTER Instruction ISSTRIAL CLASSIFICATION SYSTEM	8626	(NAICS) 923120 561720
LISHMENT INFORMATION E BUREAU OF OPERATION LEW HEATH CENTER 11557REET 3d FL& BE 11557REET 3d FL& BE N (e.g., village fire department)	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR $f_{\mathcal{A}}$	NY, DEPT OF HEALTH & MENTAL HYGINNEN
1. ESTABLISHMENT INFORMATION IMENT NAME BUREFUL DE OPERATIONS Instructions on the back of the sheet. IMENT NAME BUREFUL DE OPERATIONS IMENT NAME BUREFUL DE OPERATION IMENT NAME BUREFUL DE OPERAT	5	$NE \omega \gamma \omega \omega \nu \gamma \gamma 00 \nu$ INDUSTRY DESCRIPTION (e.g., village fire department)
1. ESTABLISHMENT INFORMATION IMENT NAME BUREAU DE DERATIONS HALLEN HEATH CENTER DRESS 1. EMPLOYENT INFORMATION 2. EMPLOYENT INFORMATION Instructions on the back of the sheet.	S MT AVERAGE NUMBER OF EMPLOYEES	ISPEAST 115STREET 3'd FL& B.
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6	S IF you don't have accurate figures, see the	ESTABLISHMENT NAME BUREAU OF OPERATION
	2. EMPLOYENT INFORMATION	1. ESTABLISHMENT INFORMATION

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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1 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

2005

I certify that I have examined t SIGNATURE Adversion MCGrath PRINT NAME Kevin McGrath		DEATHS DAYS AWAY FROM WORK JOB TRANSFER OR RESTRICTION ABLE CASES ABLE CASES (Col. I.) 0 (Col. I.) 0 (Col. J.)	3. NUMBER OF CASES	Enter the column totals from the Log of Occupational Injuries and Illnesses (correspond to the columns on the Log). If a category has no cases, enter " 0 ".
this document and that to the best of my knowl	6. CERTIFICATION	AWAY FROM 0 WORK (Col. K) JOB TRANSFER OR RESTRICTION 0 (Col. L)	4. NUMBER OF DAYS	f Occupational Injuries and Illnesses (SH 90 If a category has no cases, enter "0".
I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. IRE Item 11 Item 11 Item 11 Item 12 Item 12 Item 12		INJURIES 0 (Col. 1) SKAIN DISORDERS 0 (Col. 2) RESPIRATORY CONDITIONS 0 (Col. 2) POISONINGS 0 (Col. 3) HEARING LOSS 0 (Col. 5) ALL OTHER ILLNESSES 0 (Col. 5)	5. INJURIES AND ILLNESSES TYPES	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".
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	Entry the column total from the I are the second se
11,581	(NAICS) 923120 561120
TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	INDUSTRY DESCRIPTION (e.g., village fire department) Public Health Outpatient Clinic
6	Jackson Heights, NY 11372
AVERAGE NUMBER OF EMPLOYEES	CITY, STATE, ZP CODE
	31.32 Inotic Boulenard
Instructions on the back of the sheet.	NYC Dept. of Health & Mental Hygiene/ Corona Health Center
If you don't have accurate figures, see the	ESTABLISHMENT NAME BUREAU OF OPERATIONS

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

2005

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1. ESTABLISHMENT INFORMATION

2. EMPLOYENT INFORMATION

1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
Bureau of STD Control	If you don't have accurate figures, see the Instructions on the back of the sheet.
loor .	AVERAGE NUMBER OF EMPLOYEES
	33
INDUSTRY DESCRIPTION (e.g., village fire department)	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST VEAD
NYC Dept of Health & Mental Hygiene	IOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM	00C 83
	00,140
Occupational Injuries and Illnesses (SH 90 If a category has no cases, enter "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".
4. NUMBER OF DAYS	5. INJURIES AND ILLNESSES TYPES
	INJURIES (Col. 1)
AWAY FROM C WORK (Col. K.)	SKIN DISORDERS (Col. 2)
R OR	RESPIRATORY CONDITIONS (Col. 3)
(C	POISONINGS (Col. 4)
	HEARING LOSS
	ALL OTHER ILLNESSES
6. CERTIFICATION	
his document and that to the best of my know	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.
	DATE 2/14/2006
	ENT INFORMATION wread of STD Control Floor ef Mental Hygiens ef Mental Hygiens for compational Injuries and Illnesses (SH 9) og). If a category has no cases, enter "0". AWAY FROM WORK (Col. K) JOB TRANSFER OR RESTRICTION 6. CERTIFICATION Model his document and that to the best of my know



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

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

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SH 900.1 (12-03)
	FORM SH 900.1	2005
All establishments covered by Part 801 $\underline{\mathbf{m}}$	All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during	ional injuries or illnesses occurred during the year.
Employees, former employees, and their reits equivalent. See 801.35 and instructions	Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	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	INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME BURGU Washington Heights He	thealth Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
600 W. 1684 St.	BEMT & Har FL.	AVERAGE NUMBER OF EMPLOYEES
1	0032	F
NYC Dept o dea	a All & Mantal Lygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
(NAICS) $\mathcal{G}_{\mathcal{A}}_{$	S61720	7,472
Enter the column totals from the Log of correspond to the columns on the Log).	Occupational Injuries and Illnesses (SH 90 If a category has no cases, enter "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 ILLNESSES TYPES
>		INJURIES <u>O</u> (Col. 1)
DATHS UCOL G)	AWAY FROM (Col. K)	SKIN DISORDERS O
JOB TRANSFER OR RESTRICTION 0	JOB TRANSFER OR	RESPIRATORY CONDITIONS (Col. 3)
(0)	(Col. L.)	POISONINGS (Col. 4)
(Col. J.)		ALL OTHED ILLNESSES (Col.5)
	6. CERTIFICATION	(C0L b)
I certify that I have examined t	his document and that to the best of my know	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.
PRINT NAME thylic wynn	n - PALKER	DATE 1/25/06
SH 900.1 (12-03)		

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

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SUMMARY OF WORKRELATED INJURIES AND ILLNESSES

SH 900.1 (12-03)	I certify that have examined SIGNATURE And JA PRINT NAME And JA		(Col. J.)	JOB TRANSFER OR RESTRICTION (Col. 1.) OTHER RECORD- ABLE CASES	DEATHS DEATHS DEATHS Col. G.) DAYS AWAY FROM WORK D	3. NUMBER OF CASES	Enter the column totals from the Log o correspond to the columns on the Log).	(NAICS) 93 1 20 624 1/0	NGC Dept it Health & n	Nyc ny		NYC Early In tarde	1. ESTABLISHMENT INFORMATION	Employees, former employees, and their its equivalent. See 801.35 and instructio	All establishments covered by Part 801 J		STATE OF NEW YORK DEPARTMENT OF LABOR
	this document and that to the best of my knowle	6. CERTIFICATION		JOB TRANSFER OR RESTRICTION (Col. L.)	AWAY FROM (Col. K.)	4. NUMBER OF DAYS	Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each category (column labels correspond to the columns on the Log). If a category has no cases, enter "0".	24 NO	Tental	10013	R 1~ 303, 910 + 915	ention Program - Admini	T INFORMATION	Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	nust complete this annually, even if no occupat	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
	and that to the best of my knowledge the entries are true, accurate, and complete. TITLE $\frac{2T}{-}$ $\frac{\partial F_{FCE}}{\partial C}$ $\frac{\int C_{OD}}{-}$ DATE $\frac{2}{2}/29/06$		HEARING LOSS	$\frac{O}{(Col. 3)}$ POISONINGS $\frac{O}{(Col. 4)}$	INJURIES (Col. 1) SKIN DISORDERS (Col. 2)	5. INJURIES AND ILLNESSES TYPES)) for each category (column labels under each line	19908	Hugien e TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	31	AVERAGE NUMBER OF EMPLOYEES	If you don't have accurate figures, see the Administrations on the back of the sheet.	2. EMPLOYENT INFORMATION	m. They also have limited access to the Log (SH-900) or ese forms.	All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during the year.	SD OC	Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240

I certify that I have examined this d SIGNATURE Of Concern And Concern And Antonio PRINT NAME Vincent R. Goulbourne		DEATHS DAYS AWAY FROM WORK JOB TRANSFER OR RESTRICTION OTHER RECORD- ABLE CASES (Col. I.) (Col. I.) (Col. J.)	3. NUMBER OF CASES
I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. SIGNATURE Uncert By Uncert Cradbourne TITLE Regional Director PRINT NAME Vincent R. Goulbourne DATE 1/26/06	6. CERTIFICATION	AWAY FROM WORK24 (Col. K.)JOB TRANSFER OR RESTRICTION0 (Col. L.)	4. NUMBER OF DAYS
edge the entries are true, accurate, and TITLE Regional Director DATE 1/26/06		INJURIES SKIN DISORDERS RESPIRATORY CONDITIONS POISONINGS HEARING LOSS ALL OTHER ILLNESSES	5. INJURIES AND ILLNESSES TYPES
complete.			TYPES

(NAICS) 923120, 561710 INDUSTRY DESCRIPTION (e.g., village fire department) STREET ADDRESS **ESTABLISHMENT NAME** NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM New York City Dept of Health & Mental Hygiene Brooklyn, NY 11205 CITY, STATE, ZIP CODE **130 Nostrand Avenue** North Brooklyn Pest Control Office **1. ESTABLISHMENT INFORMATION** TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR If you don't have accurate figures, see the Instructions on the back of the sheet. AVERAGE NUMBER OF EMPLOYEES 2. EMPLOYENT INFORMATION 77,665 44

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".

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES **FORM SH 900.1** N 00 S

DEPARTMENT OF LABOR State Office Campus Building 12. Room 158 Albany NY 12240

STATE OF NEW YORK

Public Employee Safety and Health Bureau

Division of Safety and Health

Enter the column totals from the Log of Occupational Injuries and Illnesses correspond to the columns on the Log). If a category has no cases, enter "0".	AWAY FROM (Col. K.)	ES T
DAYS AWAY FROM WORK <u>(Col. H.)</u> JOB TRANSFER OR RESTRICTION <u>(Col. I.)</u>	AANSFER OR	(Col. 2) RESPIRATORY CONDITIONS (Col. 2) POISONINGS (Col. 4)
ABLE CASES (Col. J.)		HEARING LOSS (Col. 5) ALL OTHER ILLNESSES (Col. 6) (Col. 6)
	6. CERTIFICATION	
I certify that I have examined the signature Man h	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and IRE MAN TITLE CONTRACT AND TITLE	edge the entries are true, accurate, and complete. TITLE
PRINT NAME MARK KOHN	KOHN	DATE 3/10/001 0
SH 900.1 (12-03)		

NYC STREET (NAICS) 5 4/2/2 INDUSTRY DESCRIPTION (e.g.. village fire department) CITY, STATE, ZIP CODE ESTABLISHMENT NAME VC DEPT OF HEALTH AND MENTAL HAGE. NEN 151 ADDRESS WORTH YORK MANAGEMENT-INTERNAL ACCOUNTING **1. ESTABLISHMENT INFORMATION** 561110 STREET NEW 101 RUNNS 911-923 N/N HAG-IENE TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR If you don't have accurate figures, see the Instructions on the back of the sheet. AVERAGE NUMBER OF EMPLOYEES 2. EMPLOYENT INFORMATION 3

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES

FORM SH 900.1 20005

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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State Office Campus Public Employee Safety and Health Bureau Division of Safety and Health

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DATE $2/1/06$ 0 00	PRINT NAME MICHERE LONG
TITLE SV HCPPA- Heath I Safety Office	SIGNATURE / /////
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6. CERTIFICATION	6. CERTIFIC/
(Col. 6)	

3. NUMBER OF CASES	4. NUMBER OF DAYS	5. INJURIES AND ILLNESSES TYPES	TYPES
		INJURIES	0
DEATHS 0 (Col. G.)	AWAY FROM 0	SKIN DISORDERS	0
FROM WORK 0	WORK (Col. K.)		(Col. 2)
(Col. H.) JOB TRANSFER OR RESTRICTION	JOB TRANSFER OR RESTRICTION 0	RESPIRATORY CONDITIONS	(Col. 3)
(Col. I.) OTHER RECORD- 0	(Col. L.)	POISONINGS	0 (Col. 4)
ABLE CASES Col. J.)		HEARING LOSS	0
		ALL OTHER ILLNESSES	0 ^(Col. 5)
			(Col. 6)

	(INAICS) 923120 624110
63.557	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM
IOTAL HOUKS WORNED BY ALL EMPLOYEES LAST TEAR	Department of Health and Mental Hygiene
TOTAL HOUDS WODVED BY ALL EMBLOVEES LAST VEAD	INDUSTRY DESCRIPTION (e.g., village fire department)
27	New York, NY 10013
	CITY, STATE, ZIP CODE
AVERAGE NUMBER OF EMPLOYEES	40 Worth Street, 16th Floor
	STREET ADDRESS
Instructions on the back of the sheet.	Early Intervention Program - Child Find Unit
If you don't have accurate figures, see the	ESTABLISHMENT NAME
2. EMPLOYENT INFORMATION	1. ESTABLISHMENT INFORMATION
m. They also have limited access to the Log (SH-900) or tese forms.	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.

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".

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

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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.

PRINT NAME Ireth Bobb	SIGNATURE	I certify that I have examined			(Col. J.)	(Col. I.) OTHER RECORD- O	IOB TRANSFER OR RESTRICTION 0	DAYS AWAY FROM WORK 0	NEATUR 0
		I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.	6. CERTIFICATION			(Col. L.)	JOB TRANSFER OR 0	AWAY FROM 0 WORK (Col. K.)	
DATE 2/27/06	TITLE Director	edge the entries are true, accurate, and		ALL OTHER ILLNESSES	HEARING LOSS	POISONINGS	RESPIRATORY CONDITIONS	SKIN DISORDERS	INJURIES
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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME	If you don't have accurate figures, see the
Early Intervention Program/ DOHMH	Instructions on the back of the sheet.
STREET ADDRESS	
1309 Fulton Avenue 5th floor	AVERAGE NUMBER OF EMPLOYEES
CITY, STATE, ZIP CODE	
Bronx, NY 11456	40
INDUSTRY DESCRIPTION (e.g., village fire department)	
New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM	TOPEN & T. AND ALL CLARACT
(NAICS) 624110, 561110, 923120	and approximate the context of a provide a series of the s

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".

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NUMBER OF CASES

4. NUMBER OF DAYS

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INJURIES AND ILLNESSES TYPES

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

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

SUMMARY OF WORK-RELATED

INJURIES AND ILLNESSES FORM SH 900.1

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SH 900.1 (12-03)	I certify that I have examined this docu SIGNATURE Selecci Bales PRINT NAME Valerie Bales		ABLE CASES (Col. J.)	JOB TRANSFER OR RESTRICTION OTHER RECORD- ARLY CASES	DEATHS (Col. G.) DAYS AWAY (Col. G.) FROM WORK (C) WOR	3. NUMBER OF CASES 4.	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".	(NAICS) 561728 923120	TION (e.g. vil	STONX NY 10457	1826 Arthur Lvenue	ESTABLISHMENT NAME Gurcan &	1. ESTABLISHMENT INFORMATION	Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during the year	SI	DEPARTMENT OF LABOR
	ment and that to the best of my knowledge T	6. CERTIFICATION		JOB TRANSFER OR C RESTRICTION (Col. L.)	AWAY FROM Col. K)	I. NUMBER OF DAYS	tional Injuries and Illnesses (SH 900) fo egory has no cases, enter "0".	ICALION STSTEM	Lental Hygieniz	7	* Sunte is	ct Operations I	MATION	atives have the right to review this form. Ther details on access provisions for these for the set of the set	plete this annually, even if no occupational	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. IRE <u>Selecci Berley</u> TITLE <u>Health Septect Managors</u> AME <u>Valerie</u> Balley <u>DATE</u> <u>1/22/06</u>		HEARING LOSS (Col.5) ALL OTHER ILLNESSES (Col.5)	RESPIRATORY CONDITIONS (Col. 3) POISONINGS (Col. 4)	INJURIES (Col. 1) SKIN DISORDERS (Col. 2)	5. INJURIES AND ILLNESSES TYPES	or each category (column labels under each line	6,428	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	6	AVERAGE NUMBER OF EMPLOYEES	If you don't have accurate figures, see the Instructions on the back of the sheet.	2. EMPLOYENT INFORMATION	They also have limited access to the Log (SH-900) or forms.	l injuries or illnesses occurred during the year.	2005	Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240

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I certify that I have examined this SIGNATURE			(Col. J.)	(Col. I.) ABLE CASES 0	JOB TRANSFER OR RESTRICTION	(Col. G.) DAYS AWAY FROM WORK 16	DEATHS 0	3. NUMBER OF CASES
e. CERTIFICATION	CONTINUES TION			(Col. L.)	JOB TRANSFER OR RESTRICTION 10	AWAY FROM 626 WORK (Col. K.)		4. NUMBER OF DAYS
ledge the entries are true, accurate, and complete. TITLE Director, Bureau Administration/ASA DATE 1/26/06		ALL OTHER ILLNESSES	HEARING LOSS	POISONINGS	RESPIRATORY CONDITIONS	SKIN DISORDERS	INJURIES	5. INJURIES AND ILLNESSES TYPES
complete. iinistration/ASA		$0^{(Col.5)}$	0	0 (Col. 4)	0 (Col. 3)	0 (Col. 2)	16 (Col. 1)	5 TYPES

(NAICS) 923120 STREET ADDRESS New York City Department of Health and Mental Hygiene INDUSTRY DESCRIPTION (e.g., village fire department) New York, NY 10007 CITY, STATE, ZIP CODE NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM 253 Broadway, 6th, 12th, and 13th floors ESTABLISHMENT NAME Food Safety and Community Sanitation **1. ESTABLISHMENT INFORMATION** 541990 541350 TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR If you don't have accurate figures, see the AVERAGE NUMBER OF EMPLOYEES Instructions on the back of the sheet. 2. EMPLOYENT INFORMATION 372,500 190

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".

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DEPARTMENT OF LABOR STATE OF NEW YORK



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

2005

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

SUMMARY OF WORK-RELATED

INJURIES AND ILLNESSES FORM SH 900.1

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DATE 07/15/06	Mendizabel	PRINT NAME Edgar
TITLE Defuty Director	I certify that I have examined this document and that to the best of my knowledge the entries are true, accuration of the second	I certify that I have examined
	6. CERTIFICATION	
HEARING LOSS ALL OTHER ILLNESSES		
POISONINGS	RESTRICTION (Col. L.)	
RESPIRATORY CONDITIONS	JOB TRANSFER OR	JOB TRANSFER
SKIN DISORDERS	AWAY FROM (Col. K)	DEATHS (Col. C.) DAYS AWAY
INJURIES	,	\$
5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
0) for each category (column labels under each line	Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each category (column la correspond to the columns on the Log). If a category has no cases, enter "0".	Enter the column totals from the Log of correspond to the columns on the Log).
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TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	village fire department) village fire department) value el Mental Hurg iene	NYEW YOIL MY 1000/ INDUSTRY DESCRIPTION (e.g., village fire department) NYC DEDT OF Hon Hill & Montal Hug iene
1e		CITY, STATE, ZIP CODE
AVERAGE NUMBER OF EMPLOYEES	+. 21st FL.	a Lafayette S
If you don't have accurate figures, see the Instructions on the back of the sheet.	TOBACCO CONTROL	ESTABLISHMENT NAME BUREAU of T
2. EMPLOYENT INFORMATION	INFORMATION	1. ESTABLISHMENT INFORMATION
 n. They also have limited access to the Log (SH-900) or se forms. 	Employees, former employees, and their representatives have the right to review this form. They also have limited access its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	Employees, former employees, and their repits equivalent. See 801.35 and instructions
onal injuries or illnesses occurred during the year.	All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred	All establishments covered by Part 801 mu:
D 200	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240		STATE OF NEW YORK DEPARTMENT OF LABOR
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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

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1. ESTABLISHMENT INFORMATION	INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Public Health Laboratory	atory	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS		
455 First Avenue		AVERAGE NUMBER OF EMPLOYEES
CITY, STATE, ZIP CODE		
New York, NY 10016		207
Y DESCRIPTION (*)	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM	Health & Mental Hygiene.	066 166
(NAICS) 621511,621399,561110		334,320
Enter the column totals from the Log of correspond to the columns on the Log).	Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each category (column labe correspond to the columns on the Log). If a category has no cases, enter "0".	0) for each category (column labels under each line
3. NUMBER OF CASES	4. NUMBER OF DAYS	5. INJURIES AND ILLNESSES TYPES
Ð		INJURIES 2 (Col. 1)
	AWAY FROM <u>12</u> WORK <u>(Col. K.)</u>	SKIN DISORDERS $\frac{0}{(Col. 2)}$
	JOB TRANSFER OR 0	RESPIRATORY CONDITIONS $\frac{0}{(Col. 3)}$
ORD-	(Col. L.)	POISONINGS 0 (Col. 4)
ABLE CASES (Col. J.)		HEARING LOSS $\frac{0}{3}$ (Col. 5)
		(C01. 8)
	6. CERTIFICATION	
I certify that I have examined	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate,	vledge the entries are true, accurate, and complete.
SIGNATURE		TITLE City Research Scientist
PRINT NAME Jacqueline Terlonge	je	DATE 2/21/2006

STATE OF NEW YORK DEPARTMENT OF LABOR



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

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

2005

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

Albany NY 12240

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.

I certify that I have examined t SIGNATURE Recurd and the PRINT NAME Linda Brown		DEATHS DAYS AWAY FROM WORK JOB TRANSFER OR RESTRICTION ABLE CASES ABLE CASES (Col. I.) (Col. J.)	3. NUMBER OF CASES
I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. JRE Document and that to the best of my knowledge the entries are true, accurate, and complete. JRE Linda Brown DATE 1/30/06	6. CERTIFICATION	AWAY FROM WORK (Col. K.) JOB TRANSFER OR RESTRICTION 0 (Col. L.)	4. NUMBER OF DAYS
Image: orgen true of the entries are true, accurate, and TITLE Program Planner DATE 1/30/06		INJURIES SKIN DISORDERS RESPIRATORY CONDITIONS POISONINGS HEARING LOSS ALL OTHER ILLNESSES	5. INJURIES AND ILLNESSES TYPES
complete.		$\frac{3}{(\text{Col. 1})}$ $\frac{0}{(\text{Col. 2})}$ $\frac{0}{(\text{Col. 3})}$ $\frac{0}{(\text{Col. 4})}$ $\frac{0}{(\text{Col. 5})}$ $\frac{0}{(\text{Col. 5})}$	TYPES

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".

1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME	If you don't have accurate figures, see the
Bureau of STD Control - Central Office	Instructions on the back of the sheet.
STREET ADDRESS	
125 Worth Street , ROOM 207, 212, 203	AVERAGE NUMBER OF EMPLOYEES
CITY, STATE, ZIP CODE	
New York, N.Y. 10013	55
INDUSTRY DESCRIPTION (e.g., village fire department)	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
NGC Dept of Healther & Mental Hygiene	IOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM	88.076
423120, 621344, 561110	

All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during the year. SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES **FORM SH 900.1** 2005 ...

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DEPARTMENT OF LABOR Albany NY 12240

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

STATE OF NEW YORK

I certify that have examined SIGNATURE	U U .	DEATHS 0 DAYS AWAY FROM WORK 5 JOB TRANSFER OR RESTRICTION (Col. H.) OTHER RECORD- ABLE CASES (Col. J.)	3. NUMBER OF CASES
I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. IRE UCCULATION TITLE TIME THE THE AND THE THE AND THE	6. CERTIFICATION	AWAY FROM 205 WORK (Col. K) JOB TRANSFER OR 0 RESTRICTION (Col. L.)	4. NUMBER OF DAYS
vledge the entries are true, accurate, and TITLE (1004C) (1/1) DATE (1206) (1206)		SKIN DISORDERS RESPIRATORY CONDITIONS POISONINGS HEARING LOSS ALL OTHER ILLNESSES	5. INJURIES AND ILLNESSES TYPES INJURIES 7 (Co)
wheel ASk		$\begin{array}{c} 0 \\ (Col. 2) \\ (Col. 3) \\ (Col. 4) \\ (Col. 5) \\ (Col. 6) \end{array}$	S TYPES 7 (Col. 1)

(NAICS) 923120/621399 NUC NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM INDUSTRY DESCRIPTION (e.g., village fire department) JAMAICA, N.Y. 11432 CITY, STATE, ZIP CODE 90-37 Parson's Blvd. STREET ADDRESS ESTABLISHMENT NAME DEPARTMENT OF BUREAU STD CONTROL-JAMAICA 1. ESTABLISHMENT INFORMATION 101 HEALTHE T) Ì MENTAL 0 HYCLIE TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR $\mathcal{N} \in \mathcal{L}$ If you don't have accurate figures, see the AVERAGE NUMBER OF EMPLOYEES Instructions on the back of the sheet. 2. EMPLOYENT INFORMATION 50750 29

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".

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STATE OF NEW YORK DEPARTMENT OF LABOR



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

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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

I certify that I have examined this document and that to the best of my knowledge the entries are true, accurated and complete SIGNATURE AND AND TITLE AND ARE AND ARE AND ARE AND ARE	6. CERTIFICATION	ABLE CASES (Col. J.) (Col. J.) HEARING LOSS 0 ALL OTHER ILLNESSES 0 (Col. J.)
and complete		0 (Col. 5) (Col. 6)

3. NUMBER OF CASES	4. NUMBER OF DAYS	5. INJURIES AND ILLNESSES T	TYPES
0		INJURIES	(Col. 1)
DAYS AWAY FROM WORK 0	AWAY FROM (Col. K)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION 0	JOB TRANSFER OR 0	RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD- ARI E CASES 1	(Col. L.)	POISONINGS	0 (Col. 4)
(Col. J.)		HEARING LOSS	0
		ALL OTHER ILLNESSES	(Col. 5)

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".

(NAICS) 923120/621399 NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM JAAC DETARIMENI OF HEALTH & MENTAL HUGIENE 7000

1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
-BUREAU STD CONTROL-CORONA	If you don't have accurate figures, see the Instructions on the back of the sheet.
TREET ADDRESS	
34-33 Junction Blvd., 15 t F	AVERAGE NUMBER OF EMPLOYEES
CITY, STATE, ZIP CODE	
Jackson Heights, N.Y. 11372	4
NDUSTRY DESCRIPTION (e.g., village fire department)	
TEDADTMENT ON THE A	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST 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. All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during the year. INJURIES AND ILLNESSES FORM SH 900.1 900

SUMMARY OF WORK-RELATED

N

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

DEPARTMENT OF LABOR STATE OF NEW YORK

3. NUMBER OF CASES	4. NUMBER OF DAYS	5. INJURIES AND ILLNESSES TYPES
2		INJURIES (Col. 1)
DEATHS 0 DAYS AWAY (Col. G.)	AWAY FROM <u>5</u> WORK (Col. K.)	SKIN DISORDERS (Col. 2)
FROM WORK (Col. H.) JOB TRANSFER	JOB TRANSFER OR	RESPIRATORY CONDITIONS $\frac{O}{(Col. 3)}$
OR RESTRICTION (Col. I.)	RESTRICTION (Col. L.)	POISONINGS $(Col. 4)$
ABLE CASES (Col. J.)		HEARING LOSS
		ALL OTHER ILLIVESSES (Col. 6)
	6. CERTIFICATION	
I certify that I have examined	this document and that to the best of my knowle	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. JRE $\int M M M M M M M M M M M M M M M M M M $
PRINTNAME Gee Abraham	raham	DATE 2/1/06
SH 900.1 (12-03)		

NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS)923120, 621399, 561 110		125 Worth Street Rms 214-225	BUYEG Of Communicable Disease	1. ESTABLISHMENT INFORMATION	
131,544	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	AVERAGE NUMBER OF EMPLOYEES	If you don't have accurate figures, see the Instructions on the back of the sheet.	2. EMPLOYENT INFORMATION	

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".

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

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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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.

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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TITLE Halth Service Menager	las	SIGNATURE Jalener Son
dge the entries are true, accurate, and complete.	I certify that have examined this document and that to the best of my knowledge the entries are true, accurate, and complete	I certify that have examined
	6. CERTIFICATION	
(Col. 6)		
ALL OTHER ILL NESSES (Col.5)		
HEARING LOSS		ABLE CASES (Col. J.)
POISONINGS O	(Col. L.)	OTHER RECORD-
RESPIRATORY CONDITIONS (Col. 3)	JOB TRANSFER OR 180 RESTRICTION 180	JOB TRANSFER (Col. H.) OR RESTRICTION
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INJURIES (Col. 1)	- 2/2	DEATHS O
5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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".	Occupational Injuries and Illnesses (SH 900) If a category has no cases, enter "0".	Enter the column totals from the Log of Occupational Injuries and Illnesses correspond to the columns on the Log). If a category has no cases, enter "0"
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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.

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

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STATE OF NEW YORK DEPARTMENT OF LABOR

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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	2005.
All establishments covered by Part 801 m	All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during the year.	nal injuries or illnesses occurred during the year.
Employees, former employees, and their r its equivalent. See 801.35 and instruction	representatives have the right to review this form. is for further details on access provisions for these	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	T INFORMATION	2. EMPLOYENT INFORMATION
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93 Worth Street Rm: 812/125 Worth Street, Rm: 1002 CITV. STATE, ZIP CODE	rth Street, Rm: 1002	AVERAGE NUMBER OF EMPLOYEES
New York, NY 10013		50
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) 561110	CLASSIFICATION SYSTEM	87500
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3. NUMBER OF CASES	4. NUMBER OF DAYS	5. INJURIES AND ILLNESSES TYPES
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PRINT NAME	I DULA V. JULIAISON	DATE X/10/ V D



Enter the column totals from the Log. If a subgroup has no subset, enter "V".	STATE OF NEW YORK DEPARTMENT OF LABOR All establishments covered by Part 801 <u>must</u> Employees, former employees, and their reprise equivalent. See 801.35 and instructions for STREET ADDRESS STREET ADDRESS $\frac{1}{2}$ ($\frac{1}{2}$, $$	
	$ \begin{array}{c} \mbox{STATE OF NEW YORK} & \mbox{Division of Safet} & \mbox{Division of Safet} & \mbox{Division of Safet} & \mbox{Summary of WORK-RELATED} \\ \mbox{Summary of WORK-RELATED} & \mbox{Summary of WORK-RELATED} \\ \mbox{InJURIES AND ILLNESSES} & \mbox{FORM SH 900.1} & \mbox{Albany NY 1224} \\ \mbox{All establishments covered by Part 801 must} complete this annually, even if no occupational injuries or illnesses} \\ \mbox{Employees, former employees, and their representatives have the right to review this form. They also have limite is equivalent. See 801.33 and instructions for further details on access provisions for these forms. \\ \mbox{ESTABLISHMENT NAME} & \mbox{L I STATE, ZIP CODE} & \mbox{L I State ODE} & L I State IIII Structions on I Structions on I Structions on I Instructions on I I State Contractory, STATE, ZIP CODE & \mbox{L I Soc L I State III entractory of the expansion I I Structions on I Instructions on I I State I I State I I I State I I I Stat$	
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STATE OF NEW YOKK DEPARTMENT OF LABOR Division of Satety and Health DEPARTMENT OF LABOR Summary of work-relations Public Employee Safety and Health State Office Campus Building 12. Room 158 Building 12. Room 158 Albany NY 12240 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.	DEPARTMENT OF LABOR DEPARTMENT OF LABOR Sta Bui Sta Bui Sta Bui Sta Bui Sta Bui Sta Bui Alb Sta SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1 All establishments covered by Part 801 <u>must</u> complete this annually, even if no occupational injur Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	DEPARTMENT OF LABOR All establishments covered by Part 801 <u>m</u> Employees, former employees, and their r its equivalent. See 801.35 and instruction

STATE OF NEW YORK DEPARTMENT OF LABOR

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	6. CERTIFICATION	
HEARING LOSS (Col. 5) ALL OTHER ILLNESSES (Col. 6)		ABLE CASES (Col. J.)
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5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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If you don't have accurate figures, see the Instructions on the back of the sheet.	rick Chest clinic	ESTABLISHMENT NAME BUShwick
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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.	Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	Employees, former employees, and their i its equivalent. See 801.35 and instruction
All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during the year.	ust complete this annually, even if no occupatio	All establishments covered by Part 801 $\underline{\mathbf{n}}$
2665	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240		STATE OF NEW YORK DEPARTMENT OF LABOR

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
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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.	olete this summary annually, even if no occupa ves have the right to review this form. They als ess provisions for these forms.	ational injuries or illnesses occurred during the year. o have limited access to the Log (SH 900) or its equivalent.
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New York, NY , 1000	007	32
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NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).	N SYSTEM (NAICS).	54,950
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PRINT NAME JOANA Q	Quin DATE	22
SH-900.1 (2-03)		

SH 900.1 (12-03)	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. SIGNATURE Ko-S. KoAOA TITLE Health and the best of my knowledge the entries are true, accurate, and complete. PRINT NAME 1/12 Kos. KoAOA DATE 101.25.06	6. CERTIFICATION	(Col. J.) HEARING LOSS ALL OTHER ILLNESSES	····	DEATHS (Cal. G) DAYS AWAY (Cal. G) FROM WORK (Cal. H) (Cal. H) (Cal. H) (Cal. H)	3. NUMBER OF CASES 4. NUMBER OF DAYS 5. INJURIES AND ILLNES	Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each extegory (column labels under each line correspond to the columns on the Log). If a category has no cases, enter "0".	01 00 6x39 00	AMERICAN INDUSTRIAL CLASSIFICATION SYSTEMY	ISLand, NY. 10314	Miner LLE A	ESTABLISHMENT NAME 0441 CC 04 Child 1 EMPLOYE		Employees, former employees, and their representatives have the right to review this form. The state is a source during the year is equivalent.	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	•
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SH 900.1 (12-03)	PRINT NAME	I certify that I have examined d SIGNATURE			(- mark)	OTHER RECORD- (Col. I.) ABLE CASES	JOB TRANSFER			3. NUMBER OF CASES	Enter the column tatals from the Log correspond to the columns on the Log	(NATCS) 623990	DEPOLETMENT of Health and Merital H	INDUSTRY DESCRIPTION (e.g. VI	CITY, STATE, ZIP CODE	101	1. ESTABLISHME	Employees, former employees, and the its equivalent. See 801.35 and instruct	All establishments covered by Part 80		DEPARTMENT OF LABOR
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	(Cal. J.)	(Col. 1.) ABLE CASES	JOB TRANSFER (Col. H.)	ORK	INFATHS ()	3. NUMBER OF CASES	Enter the column totals from the Log of Occupation:: Injuries and Illnesses correspond to the columns on the Log). If a category has no cases, enter "0"	(NAICS) 62.3990	Department of Health and Hental He	INDUSTRY DESCRIPTION (e.g., village fire department)	CITY, STATE, ZIP CODE	STREET ADDRESS 160-15, 82 DRiv	ESTABLISHMENT NAME 044	1. ESTABLISHMENT INFORMATION	Employces, former employces, and thei its equivalent. See 801.35 and instruction	All establishments covered by Part 801	2		STATE OF NEW YORK DEPARTMENT OF LABOR
		Col. L.)	JOB TRANSFER OR	AWAY FROM		4. NUMBER OF DAYS	f Occupational Injuries and Huesses (SH 90) . If a category has no cases, enter "0".		NORTHAMERICAN INDUSTRIAL CLASSIFICATION OVERTHAMERICAN INDUSTRIAL CLASSIFICATION OVERTHAMERICAN INDUSTRIAL CLASSIFICATION OVERTHAMERICAN	, NY, 11432		60-15,82 DRIVE	le of chief	VT INFORMATION	Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms,	All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1		
ALL OTHER ILLNESSES	HEARING LOSS	POISONINGS	RESPIRATORY CONDITIONS	SKIN DISORDERS	INJURIES	5. INJURIES AND ILLNESSES TYPES	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".	00050	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	27	AVERAGE NUMBER OF EMPLOYEES	Instructions on the back of the sheet.	don't have account of	2. EMPLOYENT INFORMATION	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,	ational injuries or illnesses occurred during the year.	S S	A done Employee salery and Health Bureau State Office Campus Building 12, Room 158 Albany NY 12240	
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SH 900.1 (12-03)	I certify that I have examined the signature Kard of the second s		ABLE CASES (Col. J.)	JOB TRANSFER (Col. H.) OR RESTRICTION (Col. L.)	DEATHS (Cal. G.) DAYS AWAY (Cal. G.) FROM WORK	3. NUMBER OF CASES	Enter the column totals from the Log of correspond to the columns on the Log).	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 623990	INDUSTRY DESCRIPTION (E.g., VILLES GIVE department) Department of Health and Hen	CITY, STATE, ZIP CODE
	warnined this document and that to the best of my knowledge $\mathcal{R} \circ \mathcal{S} \circ \mathcal{B} \mathcal{D} \mathcal{R} \circ \mathcal{O} \mathcal{A}$	6. CERTIFICATION		JOB TRANSFER OR () RESTRICTION (Cal. L.)	AWAY FROM 65	4. NUMBER OF DAYS	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".	LASSIFICATION SYSTEM	INDUSTRY DESCRIPTION (e.g. village fire department) Department of Health and Hental Hygrene	East CHESTER Road
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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.

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

2. EMPLOYENT INFORMATION

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DAYS AWAY FROM WORK JOB TRANSFER OR RESTRICTION ABLE CASES (Col. J)	3. NUMBER OF CASES	Enter the column totals from the Log of correspond to the columns on the Log).	Department of Health and Mental He NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 623290	INDUSTRY DESCRIPTION (e.g., village fire department)	1 gr 1	ESTABLISHMENT NAME Office	1. ESTABLISHMENT INFORMATION	All establishments covered by Part 801 m Employces, former employees, and their r its equivalent. See 801.35 and instruction		STATE OF NEW YORK DEPARTMENT OF LABOR
AWARK FROM (Cal. K.) JOB TRANSFER OR RESTRICTION (Cal. L.)	4. NUMBER OF DAYS	fOccupational Injuries and Jilnesses (SH 90 If a category has no cases, enter "0".	hand Mental Hygicine	19, 11203 gc fire department)	, ROOM 302	office of chief	INFORMATION	All establishments covered by Part 801 <u>must</u> complete this annually, even if no occupational injur Employces, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
SKIN DISORDERS (Col.: RESPIRATORY CONDITIONS (Col.: POISONINGS (Col. 4) HEARING LOSS (Col. 5)	5. INJURIES AND ILLNESSES TYPES INJURIES (Col.	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".	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	44	AVERAGE NUMBER OF EMPLOYEES	If you don't have accurate figures, see the Instructions on the back of the sheet.	2. EMPLOYENT INFORMATION	All establishments covered by Part 801 <u>must</u> complexe this annually, even if no occupational injuries or illnesses occurred during the year. Employces, 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.	ED	Division of Safety and Health Public Employee Safety and Health Burcau State Office Campus Building 12. Room 158 Albany NY 12240
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SH 900.1 (12-03)

I certify that I have examined this document and SIGNATURE Kail Sall		DEATHS (Col. G.) DAYS AWAY FROM WORK (Col. G.) JOB TRANSFER OR RESTRICTION (Col. H.) ABLE CASES (Col. J.)	3. NUMBER OF CASES
I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and TRE VALLA SALLA THE AVIMINIS (FA) $ME \ LAILA \ SALLB \qquad DATE \ S 18/06$	6. CERTIFICATION	AWAY FROM <i>O</i> WORK (Col. K.) JOB TRANSFER OR RESTRICTION <i>O</i> (Col. L.)	4. NUMBER OF DAYS
DATE 5/18/06		INJURIES 0 (Col. 1) SKIN DISORDERS 0 RESPIRATORY CONDITIONS 0 POISONINGS 0 HEARING LOSS 0 ALL OTHER ILLNESSES 0 (Col. 5) (Col. 6)	5. INJURIES AND ILLNESSES TYPES

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".

CITY, STATE, ZIP CODE (NAICS) NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM INDUSTRY DESCRIPTION (e.g., village fire department) STREET ADDRESS ESTABLISHMENT NAME 541214 DeptioF HealtHand Mental HyGien Broadway XX **1. ESTABLISHMENT INFORMATION** 1000 1561110 0 AYRO Run 400 TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR If you don't have accurate figures, see the Instructions on the back of the sheet. AVERAGE NUMBER OF EMPLOYEES 2. EMPLOYENT INFORMATION 5 5 = 1575 X 49W =

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

Employees, former employees, and their representatives have the right to review this form. They also have limited access to the Log (SH-900) or

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

DEPARTMENT OF LABOR STATE OF NEW YORK



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

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DEPARTMENT OF LABOR		Public Employee Safety and Health State Office Campus Building 12, Room 158 Albany, NY 12240
SL	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH-900.1	5
All establishments covered by PART 801 <u>must</u> complete this summary annually, even if no occupational injuries or illnesses c Employees, former employees, and their representatives have the right to review this form. They also have limited access to the See 801.35 and instructions for further details on access provisions for these forms.	plete this summary annually, even if no occup ives have the right to review this form. They al ass provisions for these forms.	ational injuries or illnesses occurred during the year. to have limited access to the Log (SH 900) or its equivalent.
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CITY, STATE, ZIP CODE NEW YORK,	New York 10016	AVERAGE NUMBER OF EMPLOYEES
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Department of Healt	2	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
ĨĂ	N SYSTEM (NAICS).	1,820
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."	onal Injuries and Illnesses (SH 900) for eacl lory has no cases, enter "0."	category (column labels under each line
3. NUMBER OF CASES	4. NUMBER OF DAYS	5. INJURIES AND ILLNESS TYPES
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JOB TRANSFER OR RESTRICTION OTHER RECORD- ABLE CASES (Col. J.)	AWAY FROM	ALL OTHER ILLNESSES (Col. 5)
	6. CERTIFICATION	
I certify that I have examined this docu SIGNATURE Wheelas whith the	s document and that to the best of my knowledge	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. ATURE <u>initedaces unitative Los</u> TITLE <u>Associate Stall AnalySt</u> TNAME <u>NIVOLAOS MITEDEDUVOS</u> DATE <u>26 January 2006</u>
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SH-900.1 (2-03)	PRINT NAME JUANITA CH.	SIGNATURE glund Ch	I certify that I have examined this do		DEATHS (Col. G) DAYS AWAY FROM WORK (Col. H) JOB TRANSFER OR RESTRICTION (Col. H) OTHER RECORD- ABLE CASES (Col. J)	3. NUMBER OF CASES	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).	れにい とのれに、れたいとうのとれ	285 BROADWAY, 22NG FLOOR	ESTABLISHMENT NAME <u>NYC OOHMH, TUbGRCULOSE</u> STREET ADDRESS	1. ESTABLISHMENT INFORMATION	All establishments covered by PART 801 <u>must</u> complete this summary annually, e Employees, former employees, and their representatives have the right to review thi See 801.35 and instructions for further details on access provisions for these forms.	(0	DEPARTMENT, OF LABOR
	CHIW N DATE		I certify that I have examined this document and that to the best of my knowledge the entries are true,	6. CERTIFICATION	JOB TRANSFER OR RESTRICTION (Cal. K) AWAY FROM WORK (Cal. L)	4. NUMBER OF DAYS	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).	10007	LOGR	SCONTROL	TINFORMATION	All establishments covered by PART 801 <u>must</u> 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 equivation of the second	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH-900.1	
	1-26-2006	OFFICE MANGER	the entries are true, accurate, and complete.		INJURIES (Col. 1) SKIN DISORDERS (Col. 2) RESPIRATORY CONDITIONS (Col. 2) POISONINGS (Col. 3) ALL OTHER ILLNESSES (Col. 4) ALL OTHER ILLNESSES (Col. 5)	5. INJURIES AND ILLNESS TYPES	140, 800ategory (column labels under each line	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	AVERAGE NUMBER OF EMPLOYEES	If you don't have accurate figures, see the instructions on the back of this sheet.	2. EMPLOYMENT INFORMATION	ional injuries or illnesses occurred during the year. have limited access to the Log (SH 900) or its equivalent.	а а	r مسائد حاتاباناوتو معاديا عالم realin State Office Campus Building 12, Room 158 Albany, NY 12240

		SH-900.1 (2-03)
the entries are true, accurate, and complete.	examined this document and that to the best of my knowledge the entries are true, accur Surtan TITLE and TITLE and TITLE and the second	SIGNATURE Have examined this docu
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INTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR $\sim 57,100$		NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).
42	172	INDUSTRY DESCRIPTION (e.g., village fire department)
AVERAGE NUMBER OF EMPLOYEES	Blvd.	tion
If you don't have accurate figures, see the instructions on the back of this sheet.	nter	CORDINA Chest Center STREET ADDRESS
2. EMPLOYMENT INFORMATION	ESTABLISHMENT INFORMATION	2.005 " 1. ESTABLISHME
All establishments covered by PART 801 <u>must</u> 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.	<u>t</u> complete this summary annually, even if no occ entatives have the right to review this form. They a n access provisions for these forms.	All establishments covered by PART 801 must Employees, former employees, and their repres See 801.35 and instructions for further details of a
ED	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH-900.1	
Public Employee Safety and Health State Office Campus Building 12, Room 158 Albany, NY 12240		

DEATHS O DAYS AWAY FROM WORK (Col. G) JOB TRANSFER OR RESTRICTION (Col. H) OTHER RECORD- ABLE CASES	3. NUMBER OF CASES	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."	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).	TION (e.g., villag	CITY, STATE, ZIP CODE	90-37 Parsons	HENT NAME	1. ESTABLISHMENT INFORMATION	All establishments covered by PART 801 <u>must</u> 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 equinate a set and instructions for further details on access provisions for these forms.	II II	DEPARTMENT OF LABOR
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ABLE CASES (Col. J.)

6. CERTIFICATION

DSS OLARKE DATE 4/16/2007	CLARKE	I certify that I have examined SIGNATURE PRINT NAME POSS
	6. CERTIFICATION	
HEARING LOSS ALL OTHER ILLNESSES (Col. 6)		(Cối, J.)
POISONINGS (Col. 3)	JOB TRANSFER OR RESTRICTION (Col. L.)	JOB TRANSFER OR RESTRICTION (Col. I.) OTHER RECORD-
SKIN DISORDERS (Col. 2) RESPIRATORY CONDITIONS	AWAY FROM (Cốl. K.)	DEATHS (C61. G.) DAYS AWAY FROM WORK (C61. H.)
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41860	CLASSIFICATION SYSTEM	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) クえろしまし
TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	age fire department)	INDUSTRY DESCRIPTION (e.g., village fire department)
23	100013	CITY, STATE, ZIP CODE
AVERAGE NUMBER OF EMPLOYEES	THE THE 331	6 11
If you don't have accurate figures, see the Instructions on the back of the sheet.	envice of the te	ESTABLISHMENT NAME
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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.	Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	Employees, former employees, and their its equivalent. See 801.35 and instruction
ional injuries or illnesses occurred during the year.	All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during	All establishments covered by Part 801 m
Œ	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	

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

DEATHS0DAYS AWAY(Col. G.)DAYS AWAY0FROM WORK(Col. H.)JOB TRANSFER0OR RESTRICTION0OTHER RECORD(Col. I.)ABLE CASES0(Col. J.)0	Enter the column totals from the Log of correspond to the columns on the Log). 3. NUMBER OF CASES	Health NJC Dept of Healder Mental NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120	CITY, STATE, ZIP CODE New York, NY 10001	Lower Manhattan Health Center STREET ADDRESS 303-9th Ave	1. ESTABLISHMENT INFORMATION ESTABLISHMENT NAME كلالافسر مثل كل	All establishments covered by Part 801 mi Employees, former employees, and their re its equivalent. See 801.35 and instructions		STATE OF NEW YORK DEPARTMENT OF LABOR
AWAY FROM WORK <u>(Col. K.)</u> JOB TRANSFER OR RESTRICTION <u>0</u> (Col. L.)	Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each category (column lal 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 ILLNE	Dept of Healdice Mental Alggiene NDUSTRIAL CLASSIFICATION SYSTEM	na fire donartmont)	(chelsea)	INFORMATION	All establishments covered by Part 801 <u>must</u> complete this annually, even if no occupational injuries or illnesses occurred Employees, former employees, and their representatives have the right to review this form. They also have limited access its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
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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						
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	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	Ð						
All establishments covered by Part 801 $\underline{\mathbf{m}}$	<u>ust</u> complete this annually, even if no occupati	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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HMENT NAME		If you don't have accurate figures, see the Instructions on the back of the sheet.						
STREET ADDRESS	0.44							
1932 ARTHUR AVE RM CITY, STATE, ZIP CODE	403 E **	AVERAGE NUMBER OF EMPLOYEES						
BROWX WY 10457 INDUSTRY DESCRIPTION (e.g., village fire department)	ge fire department)	24						
NORTH AMERICAN INDISTRIAL CLASSIFICATION SYSTEM								
(NAICS)		045,25						
Enter the column totals from the Log of correspond to the columns on the Log).	f Occupational Injuries and Illnesses (SH 90 If a category has no cases, enter "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".						
* Employees ARE BALED A	T VARIOUS SCHOOL SI TEV							
3. NUMBER OF CASES	4. NUMBER OF DAYS	5. INJURIES AND ILLNESSES TYPES						
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(Ĉ	ROR	RESPIRATORY CONDITIONS $\frac{\mathcal{O}}{(Col. 3)}$						
OR RESTRICTION (Col. I.)	RESTRICTION (Col. L.)	POISONINGS (Col. 4)						
ABLE CASES (Col. J.)		HEARING LOSS						
		ALL OTHER ILLNESSES $\begin{array}{c} (Col. 3) \\ \rho \\ \hline \end{array}$						
	6. CERTIFICATION							
I certify that I have examined	ed this document and that to the best of my know	certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.						
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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	U
All establishments covered by Part 801 m	ust complete this annually, even if no occupati	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 raits equivalent. See 801.35 and instruction	presentatives have the right to review this forr s for further details on access provisions for 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 equivalent. See 801.35 and instructions for further details on access provisions for these forms.
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DDRESS	הניטת איון אידר דיורך	
600 W. 168 ST DENTAL CITY, STATE, ZIP CODE	L CLINIC	AVERAGE NUMBER OF EMPLOYEES
N.Y. N.Y. 1003 2 INDUSTRY DESCRIPTION (e.g. villa	village fire denartment)	~
NODTH AMEDICAN INDICATION OF A COLOR AND		TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
(NAICS)		4750
Enter the column totals from the Log of correspond to the columns on the Log).	Occupational Injuries and Illnesses (SH 90 If a category has no cases, enter "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 ILLNESSES TYPES
пратис		INJURIES <u>O</u> (Col. 1)
VORK (C	AWAY FROM <u>(Col. K)</u>	SKIN DISORDERS (Col. 2)
	JOB TRANSFER OR	RESPIRATORY CONDITIONS (Col. 3)
OK KEST KUCTION (Col. I.) OTHER RECORD-	Col. L.)	POISONINGS (Col. 4)
(Col. J.)		HEARING LOSS
		ALL OTHER ILLNESSES (Col. 5) (Col. 6)
	6. CERTIFICATION	
I certify that I have examined	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate,	TITLE Received Print.
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SH 900.1 (12-03)	I certify that I have examined SIGNATURE		(Col. J.)	OR RESTRICTION (Col. 1.) OTHER RECORD ABLE CASES () ()	JOB TRANSFER	DEATHS O O	3. NUMBER OF CASES	Enter the column totals from the Log of correspond to the columns on the Log).	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS)	INDUSTRY DESCRIPTION (elg., village fire department)		ESTABLISHMENT, NAME BUShwick	1. ESTABLISHMENT INFORMATION	All establishments covered by Part 801 mi Employees, former employees, and their re its equivalent. See 801.35 and instructions		STATE OF NEW YORK DEPARTMENT OF LABOR
	I certify that have examined this document and that to the best of my knowledge the entries are true, accurate, JRE $\frac{1}{10000000000000000000000000000000000$	6. CERTIFICATION		RESTRICTION (C_0/U)	JOB TRANSFER OR	AWAY FROM OO	4. NUMBER OF DAYS	Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each category (column lab correspond to the columns on the Log). If a category has no cases, enter "0".	LASSIFICATION SYSTEM	pe fire department)	1	STD Clinic	INFORMATION	All establishments covered by Part 801 <u>must</u> complete this annually, even if no occupational injuries or illnesses occurred Employees, former employees, and their representatives have the right to review this form. They also have the timited occess tits equivalent. See 801.35 and instructions for further details on access provisions for these forms.	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
C,	Nedge the entries are true, accurate, and complete. TITLE <u>Clinic</u> Manager DATE <u>Jan-NG</u> 2006		HEARING LOSS	POISONINGS (Col. 4)	RESPIRATORY CONDITIONS OO (Col. 3)	(Col. 1) SKIN DISORDERS	5. INJURIES AND ILLNESSES TYPES	00) for each category (column labels under each line	27,000	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	AVERAGE NUMBER OF EMPLOYEES	If you don't have accurate figures, see the Instructions on the back of the sheet.	2. EMPLOYENT INFORMATION	tional injuries or illnesses occurred during the year. rm. They also have limited occess to the Log (SH-900, or hese forms.	ED	Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240

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-	certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. RE $MMMMMMMMMMMMMMMMMMMMMMMMMMMMMMMMMMMM$	this document and that to the best of my know	I certify that I have examined
		6. CERTIFICATION	
I	ALL OTHER ILLNESSES (Col. 5) (Col. 6)		
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	POISONINGS	RESTRICTION (Col. L.)	OR RESTRICTION OO
	RESPIRATORY CONDITIONS \bigcirc \bigcirc \bigcirc	JOB TRANSFER OR	(Col.
	SKIN DISORDERS	AWAY FROM Col. K)	DEATHS
1	INJURIES O 1)
	5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	ge fire department)	Health Facility Description (e.g., village fire department)
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	AVERAGE NUMBER OF EMPLOYEES	ace	1218 Prospect T
	If you don't have accurate figures, see the Instructions on the back of the sheet.	STD Clinic	CROWN HEights
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I	iese forms.	its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	its equivalent. See 801.35 and instructions
		presentatives have the right to review this for	Employees, former employees, and their re
	ional injuries or illnesses occurred during the year.	All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred	All establishments covered by Part 801 m
	ED	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
	Building 12. Room 158 Albany NY 12240		
	Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus		STATE OF NEW YORK DEPARTMENT OF LABOR

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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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>	3. NUMBER OF CASES 4. NUMB	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".	NORTH AMERICAN INDUSTRIAL CLASSIFICATION (NAICS) $933130 - 631399$	INDUSTRY DESCRIPTION (e.g., village fire department) NYC Dent of Health and Mental Hyprene	New York, N.Y. 10013	346 Broadway 8th Floor	BURGEN OF TB CONTROL	1. ESTABLISHMENT INFORMATION	
	4. NUMBER OF DAYS	uries and Illnesses (SH 90 no cases, enter "0".	v system	al Hydreme			-	L.	
INJURIES (Col. 1)	5. INJURIES AND ILLNESSES TYPES	00) for each category (column labels under each line	70,000	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	Ho	AVERAGE NUMBER OF EMPLOYEES	If you don't have accurate figures, see the Instructions on the back of the sheet.	2. EMPLOYENT INFORMATION	

ALL OTHER ILLNESSES

(Col. 6)

		JOB TRANSFER OR RESTRICTION OTHER RECORD- ABLE CASES (Col. J.)	DEATHS (Col. G.) DAYS AWAY (Col. G.) FROM WORK (Col. H.)	3. NUMBER OF CASES	Enter the column totals from the Log of Occupational Injuries and Illnesses correspond to the columns on the Log). If a category has no cases, enter "0"	(NAICS) $923/20 - 6/1699$	NORTH AMEDICAN INTER HOAC	NEW YORK, N.Y. 10007	253 BRCADUAY CITY, STATE, ZIP CODE	BUREAU OF TO CON STREET ADDRESS	1. ESTABLISHMENT INFORMATION	Employees, former employees, and their its equivalent. See 801.35 and instruction	All establishments covered by Part 801	STATE OF NEW YORK DEPARTMENT OF LABOR
		RESTRICTION (Col. L.)	AWAY FROM (Col. K.)	4. NUMBER OF DAYS	f Occupational Injuries and Illnesses (SH 90 . If a category has no cases, enter "0".	$\frac{611699}{611699}$	ACTH & HENTAL HYGIENE	1007	ROCH 602	B CONTROL-EUCHTION + TRAINING	AT INFORMATION	Employees, former employees, and their representatives have the right to review this form. They also have limited access its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
(Col. 6)	LNESSES	RESPIRATORY CONDITIONS (Col. 3) POISONINGS (Col. 4) HEARING LOSS	INJURIES (Col. 1) SKIN DISORDERS (Col. 2)	5. INJURIES AND ILLNESSES TYPES	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".	20530	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	12	AVERAGE NUMBER OF EMPLOYEES	If you don't have accurate figures, see the Instructions on the back of the sheet.	2. EMPLOYENT INFORMATION	vational injuries or illnesses occurred during the year. Form. They also have limited access to the Log (SH-900) or these forms.	S	Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240



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 SH 900.1 (12-03)

PRINT NAME Burt Roberts	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.	6. CERTIFICATION	DN 0 D- 0 (Col. I.) (Col. J.)	(Col. H.) IOR TRANSFER OR
DATE Ja. 24,06	y knowledge the entries are true, accurate, and complete. TITLE Health Service Manager	FION	POISONINGS HEARING LOSS ALL OTHER ILLNESSES	RESPIRATORY CONDITIONS 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".

DAYS AWAY FROM WORK

(Col. G.) 0

AWAY FROM WORK

(Col. K.) 0

SKIN DISORDERS

(Col. 2)

0

(Col. 1)

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DEATHS

3

NUMBER OF CASES

4

NUMBER OF DAYS

5. INJURIES AND ILLNESSES TYPES

INJURIES

9440	(NAICS) 561720 - 923120
0447	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM
TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	New York City Department of Health and Mental Hygiene
	INDUSTRY DESCRIPTION (e.g., village fire department)
СЛ	Brooklyn, New York 11229
	CITY, STATE, ZIP CODE
AVERAGE NUMBER OF EMPLOYEES	1601 Avenue 'S'
	STREET ADDRESS
Instructions on the back of the sheet.	Bureau of Operations, Homecrest District Health Center
If you don't have accurate figures, see the	ESTABLISHMENT NAME

1. ESTABLISHMENT INFORMATION 2. EMPLOYENT INFORMATION

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.

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

STATE OF NEW YORK DEPARTMENT OF LABOR

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

Division of Safety and Health

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I certify that have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.	6. CERTIFICATION	3. NUMBER OF CASES 3. NUMBER OF CASES DEATHS DEATHS DAYS AWAY FROM WORK JOB TRANSFER OR RESTRICTION ABLE CASES (Col. C.) JOB TRANSFER OR AWAY FROM Col. K.) JOB TRANSFER OR (Col. J.) Col. J. Col. J. Col. J. Col. J. Col. L. Col. L.
vledge the entries are true, accurate, and complete. TITLE MO DATE $23/06$		5. INJURIES AND ILLNESSES TYPES INJURIES INJURIES SKIN DISORDERS RESPIRATORY CONDITIONS POISONINGS HEARING LOSS ALL OTHER ILLNESSES (Col. 5) (Col. 5)

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"

	-	T	1	1	1
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS)	NUC Rest. of Ika/Hud Mental Hugiera	New York, N.Y 10013	125 Warth St. Cm 1047 '	STREET ADDRESS Collica Commity Rections AMD	1. ESTABLISHMENT INFORMATION
29,000	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	11	AVERAGE NUMBER OF EMPLOYEES	If you don't have accurate figures, see the Instructions on the back of the sheet.	2. EMPLOYENT INFORMATION

STATE OF NEW YORK DEPARTMENT OF LABOR



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.

Division of Safety and Health Public Employee Safety and Health Bureau

PRINT NAME OLIVIA MERA	I certify that I have examined the			ABLE CASES (Col. J.)	OTHER RECORD-	JOB TRANSFER	DAYS AWAY EDAYS AWAY		3. NUMBER OF CASES	Enter the column totals from the Log of Occupational Injuries and Illnesses (correspond to the columns on the Log). If a category has no cases, enter "0".
e A	is document and that to the best of my knowledge	6 CEDTIFICATION			RESTRICTION (Col. L.)	JOB TRANSFER OR	AWAY FROM (Col. K.)		4. NUMBER OF DAYS	Occupational Injuries and Illnesses (SH 900 If a category has no cases, enter "0".
DATE $\frac{1/30/06}{2}$	I certify that Thave examined this document and that to the best of my knowledge the entries are true, accurate, and complete.		ALL OTHER ILLNESSES	HEARING LOSS	POISONINGS	RESPIRATORY CONDITIONS (Col. 3)	SKIN DISORDERS	INJURIES (Con. 1)	5. INJURIES AND ILLNESSES TYPES	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".

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES **FORM SH 900.1** Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240 Division of Safety and Health

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.

SH 900.1 (12-03)

ATMENT OF LABOR JF NEW YORK

			SH 900.1 (12-03)
1/30/06	DATE	ERA	PRINT NAME OLIVIA M
tries are true, accurate, and complete. $\mathcal{PM} \circ$	vledge the en	I certify that I have examined this document and that to the best of my knowledge the entries are true, $\frac{1}{1} = \frac{1}{1} \frac$	I certify that I have examined
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POISONINGS (Col. 4)	POISO	(Col. L.)	ABLE CASES (Col. I.)
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11,000		CLASSIFICATION SYSTEM	(NAICS)
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6	20	12	OW YORK N.
AVERAGE NUMBER OF EMPLOYEES	AVE	lm 329	125 Warth St.
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es or illnesses occurred during the year.	ational injurie	All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during the year.	All establishments covered by Part 801
	TED	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
State Office Campus Building 12. Room 158 Albany NY 12240	State Buil Albe		
Division of Safety and Health Public Employee Safety and Health Bureau	Divi Publ		JF NEW YORK TMENT OF LABOR

DATE 1/30/06	A MERA	PRINT NAME OLIVI
are true, acc	examined this document and that to the best of my knowledge the entries	I certify that I have examined
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HEARING LOSS (Col. 5) ALL OTHER ILLNESSES (Col. 5)		ABLE CASES (Col. J.)
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5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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".	Occupational Injuries and Illnesses (SH 90 If a category has no cases, enter "0".	Enter the column totals from the Log of correspond to the columns on the Log).
21,595	LASSIFICATION SYSTEM	AN INDUS
TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	village fire department)	DESCRIPTION (e.g.
12	E100	NPIN YOK NY
AVERAGE NUMBER OF EMPLOYEES	m 342	125 Wath St. R
If you don't have accurate figures, see the Instructions on the back of the sheet.	G Rublications	ESTABLISHMENT NAME
	INFORMATION	1. ESTABLISHMENT INFORMATION
n. They also have limited access to the Log (SH-900) or ese forms.	Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	Employees, former employees, and their re its equivalent. See 801.35 and instructions
onal injuries or illnesses occurred during the year.	All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred	All establishments covered by Part 801 mu
CD	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240		JF NEW YORK ATMENT OF LABOR

SH 900.1 (12-03)	1 certify that I have exan SIGNATURE		DAYS AWAY FROM WORK JOB TRANSFER OR RESTRICTION OTHER RECORD- ABLE CASES (Col. J.)
	nined this document and that to the market of the the second seco	6. CE	AWAY FROM WORK JOB TRANSFER OR RESTRICTION
	best of my knowled	6. CERTIFICATION	(Col. K) (Col. L.)
	I certify that I have examined this document and that to the set of my knowledge the entries are true, accurate, and complete. JRE UNUT . UNUL TITLE Center Administration of the set of t		SKIN DISORDERS RESPIRATORY CONDITIONS POISONINGS HEARING LOSS ALL OTHER ILLNESSES
	ustrative Manager		(Col. 2) (Col. 3) (Col. 4) (Col. 5) (Col. 5)
	9		

NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS)	INDUSTRY DESCRIPTION (e.g., village fire department)	Ven Vork, W.Y. 1000/	303 Ninth Avenue	ESTABLISHMENTNAME Che Sea Chest Eender	1. ESTABLISHMENT INFORMATION	
32,641	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	L C	AVERAGE NUMBER OF EMPLOYEES	If you don't have accurate figures, see the Instructions on the back of the sheet.	2. EMPLOYENT INFORMATION	

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".

DEATHS

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NUMBER OF CASES

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INJURIES AND ILLNESSES TYPES

INJURIES

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

STATE OF NEW YORK DEPARTMENT OF LABOR

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(Col. J.)	HEARING LOSS 0
	ALL OTHER ILLNESSES $0^{(Col. 3)}$ (Col. 6)
	6. CERTIFICATION
I certify that I have examined	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.
SIGNATURE	muprin Almin NSOC
PRINT NAMELLIA CHAC	ASK/11 DATE 2/7/06
SH 900.1 (12-03)	

(Col. J.)	OTHER RECORD- ABLE CASES 0	JOB TRANSFER 0	Col. C.) DAYS AWAY EDOM WORK 0	DEATHS 0	3. NUMBER OF CASES
	(Col. L.)	JOB TRANSFER OR	AWAY FROM 0 WORK (Col. K.)		4. NUMBER OF DAYS
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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".

10920	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS)
TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	INDUSTRY DESCRIPTION (e.g., village fire department) Department of Health and Mental Hygiene
σ	NEW YORK, NY 10013
	CITY, STATE, ZIP CODE
AVERAGE NUMBER OF EMPLOYEES	125 WORTH STREET ROOM 623
	STREET ADDRESS
Instructions on the back of the sheet.	NYC DOHMH DIVISION OF FINANCIAL STRATEGIC MANAGEME
If you don't have accurate figures, see the	ESTABLISHMENT NAME CHARVES THE MILL
2. EMPLOYENT INFORMATION	1. ESTABLISHMENT INFORMATION

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.

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

Building 12. Room 158 Albany NY 12240 State Office Campus

DEPARTMENT OF LABOR Division of Safety and Health Public Employee Safety and Health Bureau

STATE OF NEW YORK

DEPARTMENT OF LABOR SUMMARY OF WORK RELATED INJURIES AND FLANSES SumMARY OF WORK RELATED INJURIES AND FLANSES All stabilishmens covered by Part 901 mist complete this annually, even if no occupational injuries or filmsses occurred during the year. Employees, former employees, and their processing for further details on access provisings for these forms. It equivalent. See 801.53 and instructions for further details on access provisings for these form. Employees, former employees, and their representatives have the right to aveise this form. They also have initiad access to the Log (SH-900) or It equivalent. See 801.53 and instructions for further details on access provisings for these forms. Employees, former employees, and their representatives this form. They also have initiad access to the Log (SH-900) or It equivalent. See 801.53 and instructions for further details on access provisings for these forms. Employees, former employees, and the Deg (SH-900) for the Employee State of the sheet. Store of Large Direct the columns on the Log of Occupational Liparities and Illnesses (SH 900) for each category foolumn labels under each like emprovement of the columns on the Log. If a entegory has an easter, enter "U". NUMBER OF CASES 4. NUMBER OF DAYS Store of Column in the Log. If a entegory fixe and Illnesses (SH 900) for each category foolumn labels under each like enters of the columns on the Log. If a entegory has an easter, enter "U". DAX MAWAY ROAN Col. K. NUMBER OF CASES 4. NUMBER OF DAYS Store Direction Column 5. INUREES AND ILLINE	ER OF DAYS 5. INJURIES AND ILLNESSES TY INJURIES INJURIES INJURIES INJURIES INJURIES INJURIES INJURIES AND ILLNESSES TY INJURIES AND ILLNESSES TY INJURIES AND ILLNESSES TY	CITY, STATE, ZIP CODE CITY, STATE, ZIP CODE B (\bigcirc KL \bigcirc N \bigcirc N \bigcirc II) INDUSTRY DESCRIPTION (c.g. village fire du N \bigcirc C \bigcirc C \bigcirc H \bigcirc H \frown II) NORTH AMERICANTINDUSTRIAL CLASSIFI (NAICS) \bigcirc 2.1.2.1.0 \bigcirc \bigcirc NORTH AMERICANTINDUSTRIAL CLASSIFI (NAICS) \bigcirc 2.1.2.1.0 \bigcirc \bigcirc Enter the column totals from the Log of Occupated to the columns on the Log of Occupated to the columns on the Log). If a care correspond to the columns on the Log. If a care DEATHS \bigcirc
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OR Public Employee Safety an Stare Office Campus Building 12. Room 158 Albany NY 12240 INJURIES AND ILLNESSES FORM SH 900.1	mplate this annually, even if no occupational injuries or illnesses occurred during the year. ntatives have the right to review this form. They also have limited access to the Log (SH-900) or arther details on access provisions for these forms.	All establishments covered by Part 801 <u>must</u> comp Employees, former employees, and their representa its equivalent. See 801.35 and instructions for furd
	Public Employee Safety an State Office Campus Building 12. Room 158 Albany NY 12240	OR

P.03/05

OHPP REGION FOUR

FEB-03-2006 16:02

SH 900.1 (12-03)	I certify that I have examined the SIGNATURE STOLLAD A		DEATHS DAYS AWAY FROM WORK JOB TRANSFER OR RESTRICTION OTHER RECORD ABLE CASES (Cal. I.) (Cal. J.)	3. NUMBER OF CASES	Enter the column totals from the Log of (correspond to the columns on the Log). 1	DEPARTMENT OF LABOR SUMMARY INJURIES SUMMARY INJURIES FO All establishments covered by Part 801 <u>must</u> complete this anni Employees, former employees, and their representatives have the its equivalent. See 801.35 and instructions for further details on ESTABLISHMENT NAME OR AL HEALT DROST ONCH A UP NAL CITY, STATE, ZIP CODE STREET ADDRESS 352.5 NOST ONCH A UP NAL CITY, STATE, ZIP CODE Dr of KI of A HEALT HAVE department NORTH AMERICAN INDUSTRIAL CLASSIFICATIONS (NAICS) 6 & 1.2.10 9.2.3.12	STATE OF NEW YORK
	that I have examined this document and that to the best of my knowledge the entries are true, accurate, and Authon of a contract of the best of my knowledge the entries are true, accurate, and TITLE Regional AD TITLE Regional AD TITLE Regional AD DATE 2-1-06	6. CERTIFICATION	AWAY FROM (Cal. K.) JOB TRANSFER OR (Cal. K.) RESTRUCTION (Col. L.)	4. NUMBER OF DAYS	Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each category (column labels correspond to the columns on the Log). If a category has no cases, enter "0".	DEPARTMENT OF LABOR SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORMS IND ULLNESSES FORMS I 900.1 All Sta Employees, former employees, and their representatives have the right to review this form. They is equivalent. See 801.35 and instructions for further details on access provisions for these forms. They are applyees, so the instructions for further details on access provisions for these forms. STREET ADDRESS STREET ADDRESS STREET ADDRESS STREET ADDRESS STREET ADDRESS STREET ADDRESS STREET ADDRESS MUT . ILLLS NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM MUT C. D. OL AL HEALTH & MC MALL HUG IVAN MALCS MALCS MALCS	
	the entries are true, accurate, and complete. TITLE REGIONALADM. D.C.		INJURIES (Col. 1) SKIN DISORDERS (Col. 1) RESPIRATORY CONDITIONS (Col. 2) POISONINGS (Col. 3) POISONINGS (Col. 4) HEARING LOSS (Col. 4) HEARING LOSS (Col. 6)	5. INJURIES AND ILLNESSES TYPES) far each category (column labels under each line	DEPARTMENT OF LABOR SUMMARY OF WORK-RELATED SumMARY OF WORK-RELATED Indiduct 12: Room 158 Building 12: Room 158 All stablishnents 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 is equivalent. See 801.35 and instructions for further ideals on access provisions for these forms. I. ESTABLISHMENT INFORMATION I. ESTABLISHMENT INFORMATION I. ESTABLISHMENT INFORMATION I. ENPLOYENT INFORMATION I. ESTABLISHMENT INFORMATION I. ESTABLISHMENT INFORMATION I. ESTABLISHMENT INFORMATION I. ENTROPORT CONCLUSION for these forms. ISTREET ADDRESS NORTH A U.e. N.M.L. G. STREET ADDRESS J. OL O.I. A. W.F. A. W.F. ALLAN A WOR IN A CLASSIFICATION SYSTEM TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR NORTH A MERICAN INDUSTRIAL CLASSIFICATION SYSTEM TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR NORTH A MERICAN INDUSTRIAL CLASSIFICATION SYSTEM TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR NORTH A MERICAN INDUSTRIAL CLA	Division of Safety and Health

P. 02/05

OHPP REGION FOUR

FEB-03-2006 16:01

ESTABLISHMENT NAME FSM/PPQD, Policy & Planning		If you don't have accurate rigures, see the Instructions on the back of the sheet.	
STREET ADDRESS			
125 Worth Street, RM 624		AVERAGE NUMBER OF EMPLOYEES	
CITY, STATE, ZIP CODE			
New York, N.Y. 10013		15	
INDUSTRY DESCRIPTION (e.g., village fire department) New York City Department of Health & Mental Hygiene	ge fire department) Ith & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM	LASSIFICATION SYSTEM	26 300 Hours	
(NAICS) 561110 541990			
			L
Enter the column totals from the Log of correspond to the columns on the Log).	Occupational Injuries and Illnesses (SH 90 If a category has no cases, enter "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".	l
3. NUMBER OF CASES	4. NUMBER OF DAYS	5. INJURIES AND ILLNESSES TYPES	
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DAYS AWAY EDOM WORK 0	AWAY FROM 0 WORK (Col. K.)	SKIN DISORDERS 0 (Col. 2)	
JOB TRANSFER OR RESTRICTION 0	JOB TRANSFER OR RESTRICTION 0	RESPIRATORY CONDITIONS 0 (Col. 3)	
(Col. I.) ARTY CASES 0	(Col. L.)	POISONINGS 0 (Col. 4)	
(Col. J.)		HEARING LOSS 0	
		ALL OTHER ILLNESSES (Col. 6)	I
	6. CERTIFICATION		
I certify that I have examined	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate,	vledge the entries are true, accurate, and complete.	
PRINT NAME Dodsey Cyrus	0	DATE 1/31/06	
SH 900.1 (12-03)			



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

DEPARTMENT OF LABOR STATE OF NEW YORK



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

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	If you don't have accurate figures, see the
Bureau of Correctional Health Services-Vernon C. Bain Center	Instructions on the back of the sheet.
STREET ADDRESS	
1 Hallack Street	AVERAGE NUMBED OF EMDI OVERS
CITY, STATE, ZIP CODE	
Bronx, New York 10474	15
INDUSTRY DESCRIPTION (e.g., village fire department)	
New York City Dept. of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM	06 050
(1741-5) 9213120, 621399	20,200

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".

			(Col. J.)	OTHER RECORD- ARLE CASES 0	JOB TRANSFER OR RESTRICTION 0	Col. G.) FROM WORK 0	DEATHS 0	3. NUMBER OF CASES
6. CERTIFICATION				(Col. L.)	JOB TRANSFER OR RESTRICTION 0	AWAY FROM U WORK (Col. K.)	2	4. NUMBER OF DAYS
	-	ALL OTHER ILLNESSES	HEARING LOSS	POISONINGS	RESPIRATORY CONDITIONS	SKIN DISORDERS	INJURIES	5. INJURIES AND ILLNESSES T
	(001.0)	(Col. 5)	0	(Col. 4)	0 (Col. 3)	0 (Col. 2)	0 (Col. 1)	TYPES

SH 900.1 (12-03)

DATE 2/7/2006

Dir. of Credentialing & Accreditation

PRINT NAME SIGNATURE < Jaime Rivera

delle merp

TITLE

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

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NUMBER OF CASES NUMBER OF CASES NUMBER OF CASES AWAY AWAY I WORK I WORK I RANSFER O STRICTION I Col. G.) RRECORD- 1 CASES I certify that I have examined ATURE Jaime Rivera	(NAICS) 9213120, 621399
Output for columns on the Log. If a category has no cases, enter "0". 3. NUMBER OF CASES 4. NUMBER OF DAYS DEATHS 0 DEATHS (Col. G.) DAYS AWAY (Col. G.) FROM WORK 1 OB TRANSFER OR RESTRICTION (Col. H.) OB TRANSFER OR 0 OTHER RECORD- 1 1 (Col. I.) OTHER RECORD- 1 1 (Col. J.) JOB TRANSFER OR 0 (Col. I.) JOB TRANSFER OR 0 OTHER RECORD- 1 OB TRANSFER OR 0 I certify that 1 have examined this document and that to the best of my know SIGNATURE Jaimle Rivera PRINT NAME Jaimle Rivera	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 9213120, 621399
Outcome commendation Conserve of the columns on the Log. If a category has no cases, enter "Q". S. INJURIES AND ILLNESSES TYPES 3. NUMBER OF CASES 4. NUMBER OF DAYS 5. INJURIES AND ILLNESSES TYPES DEATHS	89,250

Bureau of Correctional Health Services-Administration	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS	
225 Broadway, Floors 17 & 23	AVERAGE NI IMBED OF EMDI OVEES
CITY, STATE, ZIP CODE	AT EASTER NOMBER OF EMFLOTIEES
New York, New York 10007	51
INDUSTRY DESCRIPTION (e.g., village fire department)	
New York City Dept. of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM	
(INAICS) 9213120. 621399	052,68



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

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I certify that I have examined SIGNATURE ALIVE I PRINT NAME Jaime Rivera		3. NUMBER OF CASES DEATHS DAYS AWAY FROM WORK JOB TRANSFER OR RESTRICTION OTHER RECORD- ABLE CASES (Col. J.)	Enter the column totals from the Log of Occupational Injuries and Illnesses (correspond to the columns on the Log). If a category has no cases, enter "0".
ivera	6. CERTIFICATION	4. NUMBER OF DAYS AWAY FROM 0 WORK (Col. K.) JOB TRANSFER OR RESTRICTION 0 (Col. L.)	f Occupational Injuries and Illnesses (SH 90 If a category has no cases, enter "0".
I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. INE		5. INJURIES AND ILLNESSES TYPES INJURIES 1 SKIN DISORDERS 0 RESPIRATORY CONDITIONS 0 POISONINGS 0 HEARING LOSS 0 ALL OTHER ILLNESSES 0 (Col. 5) 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".

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME	If you don't have accurate figures see the
Bureau of Correctional Health Services-Rikers Island	Instructions on the back of the sheet.
STREET ADDRESS	
1606 Hazen Street (West Facility Trailer)	AVED ACE AND ADED OF FAMILY OFFEN
CITY, STATE, ZIP CODE	AV ENAGE NUMBER OF EMPLOYEES
Queens, New York 11365	91
INDUSTRY DESCRIPTION (e.g., village fire department)	
New York City Dept. of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM	
(INAICS) 9213120, 621399	159,250

SH 900.1 (12-03)

DATE 2/7/2006		PRINT NAME Jaime Rivera
I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. IRE	this document and that to the best of my knowler	I certify that I have examined
	6. CERTIFICATION	
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ALL OTHER ILLNESSES		
HEARING LOSS 0		(Col. J.)
POISONINGS 0 (Col. 4)	(Col. L.)	OTHER RECORD- ABLE CASES 0
RESPIRATORY CONDITIONS 0 (Col. 3)	JOB TRANSFER OR RESTRICTION 0	JOB TRANSFER OR RESTRICTION 0
SKIN DISORDERS 0 (Col. 2)	AWAY FROM U WORK (Col. K.)	Col. G.) FROM WORK 0
INJURIES <u>0</u> (Col. 1))	DEATHS 0
5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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".	f Occupational Injuries and Illnesses (SH 900) If a category has no cases, enter "0".	Enter the column totals from the Log of correspond to the columns on the Log).
		9213120, 621399
36 750	LASSIFICATION SYSTEM	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM
TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR		New York City Dept. of Health and Mental Hygiene
21		Astoria, New York 11105
A VENAUE NUMBER OF EMPLOTEES		CITY, STATE, ZIP CODE
AVED ACE AND ADED OF FAMILY AVED		18-39 42 Street
		STREET ADDRESS
Instructions on the back of the sheet.	rvices-Warehouse (CMS)	Bureau of Correctional Health Services-Warehouse (CMS)
If you don't have accurate frames and the		ESTABLISHMENT NAME

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

STATE OF NEW YORK DEPARTMENT OF LABOR

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2. EMPLOYENT INFORMATION

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

DATE 1/18/06	Juer	PRINT NAME MARIA Rodriguez
tige the entries are true, accurate, and complete.	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and TIRE MELLE DIES / S. P. H. H.	I certify that I have examined the SIGNATURE
	6. CERTIFICATION	
ALL OTHER ILLNESSES (Col. 3)		
HEARING LOSS		ABLE CASES (Col. J.)
RESPIRATORY CONDITIONS (Col. 3)	JOB TRANSFER OR RESTRICTION (Col. L.)	JOB TRANSFER OR RESTRICTION
(Col. 1) (Col. 2)	AWAY FROM WORK (C6L K.)	
INJURIES		× .
5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
0) for each category (column labels under each line	Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each category (column labels correspond to the columns on the Log). If a category has no cases, enter "0".	Enter the column totals from the Log o correspond to the columns on the Log)
NA 25	CLASSIFICATION SYSTEM	(NAICS)
TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR		Dept of Health.
		NUL NY 10013
AVERAGE NUMBER OF EMPLOYEES	and Floot	158 ELIISSTU CITY, STATE, ZIP CODE
If you don't have accurate figures, see the Instructions on the back of the sheet.	D Control (EAST Henley)	STREET ADDRESS
2. EMPLOYENT INFORMATION	T INFORMATION	1. ESTABLISHMENT INFORMATION
m. They also have limited access to the Log (SH-900) or ese forms.	Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	Employees, former employees, and their its equivalent. See 801.35 and instruction
All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during the year.	<u>must</u> complete this annually, even if no occupati	All establishments covered by Part 801 I
	INJURIES AND ILLNESSES FORM SH 900.1	

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> 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

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		SH 900.1 (12-03)
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	6. CERTIFICATION	
HEARING LOSS (Col. 5) ALL OTHER ILLNESSES (Col. 6)		(Col. J.)
POISONINGS (Col. 4)	(Col. L.)	(Col. L) ABLE CASES
RESPIRATORY CONDITIONS (Col. 3)	JOB TRANSFER OR	JOB TRANSFER (Col. H.)
SKIN DISORDERS (Col. 2)	AWAY FROM <u>~ /</u> WORK (Col. K.)	DAYS AWAY FROM WORK
INJURIES (Col. 1)	5	DEATHS
5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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".	f Occupational Injuries and Illnesses (SH 90 . If a category has no cases, enter "0".	Enter the column totals from the Log c correspond to the columns on the Log)
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TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	HYGIENE	NYC DEPT OF HEALTH & MENTAL KYCI
3 /0	NY 11415 are fire denartment)	KEW GARDENS NY 11415 INDUSTRY DESCRIPTION (e.g. village fire department)
AVERAGE NUMBER OF EMPLOYEES	Bus	120 - 34 Q VEENS CITY, STATE, ZIP CODE
If you don't have accurate figures, see the Instructions on the back of the sheet.	TH REGIONAL OFFICE	ESTABLISHMENT NAME BURGAU & UEENS SCHOOL HEALTH STREET ADDRESS
2. EMPLOYENT INFORMATION	INFORMATION	1. ESTABLISHMENT INFORMATION
n. They also have limited access to the Log (SH-900) or ese forms.	Employees, former employees, and their representatives have the right to review this form. They also have limited access to the its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	Employees, former employees, and their its equivalent. See 801.35 and instruction
onal injuries or illnesses occurred during the year.	All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred durin	All establishments covered by Part 801 n
G 3	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240		STATE OF NEW YORK DEPARTMENT OF LABOR

DATE Tel 2006	40026	PRINTNAME Robert
I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.	this document and that to the best of my know $\mathcal{A} = \mathcal{A}$	I certify that I have examined
	6. CERTIFICATION	
ALL OTHER ILLNESSES		
HEARING LOSS		ABLE CASES (Col. J.)
POISONINGS (Col. 4)	(Col. L.)	OTHER RECORD-
RESPIRATORY CONDITIONS O (Col. 3)	JOB TRANSFER OR	JOB TRANSFER
SKIN DISORDERS (Col. 2)	AWAY FROM (Col. K.)	(Col. G.) FROM WORK
(Col. 1)	-	DEATHS
5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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".	f Occupational Injuries and Illnesses (SH 90 If a category has no cases, enter "0".	Enter the column totals from the Log of correspond to the columns on the Log).
286, 320	CLASSIFICATION SYSTEM	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS)
TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	(ge lire department)	INDUSTRY DESCRIPTION (e.g., village tire department) Hered Department
171	a for	Ne Jork re
AVERAGE NUMBER OF EMPLOYEES	S	- forete
If you don't have accurate figures, see the Instructions on the back of the sheet.	ut of feed and mater	ESTABLISHMENT NAME New YORK CITS Department of STREET ADDRESS
2. EMPLOYENT INFORMATION	INFORMATION	1. ESTABLISHMENT INFORMATION
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tional injuries or illnesses occurred during the year.	All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during	All establishments covered by Part 801 mt
ED	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
Public Employee Sately and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240		DEPARTMENT OF LABOR
Division of Safety and Health	IA A	STATE OF NEW YORK

		SH 900.1 (12-03)
DATE 1/31/06	D. SMITH	PRINT NAME 70N1
TITLE <u>REGIONAL</u> ADM. DIECTOR	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete IRE $\int C_{n} C_$	I certify that I have examined
	6. CERTIFICATION	
HEARING LOSS (Col. 5) ALL OTHER ILLNESSES (Col. 6)		(Col. J.)
POISONINGS	JOB TRANSFER OR RESTRICTION (Col. L.)	JOB TRANSFER OR RESTRICTION OTHER RECORD- ABLE CASES
INJURIES (Col. 1) SKIN DISORDERS (Col. 2)	AWAY FROM Col. K.)	DEATHS O DAYS AWAY FROM WORK
5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR		$\frac{N(I)}{INDUSTRY DESCRIPTION (e.g., village fire department)}$
AVERAGE NUMBER OF EMPLOYEES	AVENUE	303 NINTH AN CITY, STATE, ZIP CODE
If you don't have accurate figures, see the Instructions on the back of the sheet.	DENTALCLINIC (D.H.IC)	ESTABLISHMENT NAME NUC-
2. EMPLOYENT INFORMATION	ESTABLISHMENT INFORMATION	1. ESTABLISHMEN
m. They also have limited access to the Log (SH-900) or ese forms.	Employees, former employees, and their representatives have the right to review this form. They also have limited access to the its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	Employees, former employees, and their its equivalent. See 801.35 and instructic
All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during the year.	must complete this annually, even if no occupati	All establishments covered by Part 801
	FORM SH 900.1	

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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

NEW VIEW, NIAGE THE department) NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) $3.3.120$ 56/1/10	AN INDUSTRIAL CLASSIFICATION SYSTEM	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR $\frac{29.750}{150}$
Enter the column totals from the Log of Occupational Injuries and Illnesses correspond to the columns on the Log). If a category has no cases, enter "0"	f Occupational Injuries and Illnesses (SH 90 If a category has no cases, enter "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 ILLNESSES TYPES
DEATHS (Col. C.) DAYS AWAY FROM WORK (O	AWAY FROM O WORK (Col. K.)	INJURIES (Col. 1) SKIN DISORDERS (Col. 2)
JOB TRANSFER OR RESTRICTION (Col. H.) OTHER RECORD- ABLE CASES	JOB TRANSFER OR RESTRICTION (Col. L.)	RESPIRATORY CONDITIONS $(Col. 3)$ POISONINGS $(Col. 4)$
(CGL, J.)		HEARING LOSS (Col. 5)
		(Col. 6)
I certify that I have examined t SIGNATURE	6. CERTIFICATION	1 certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. JRE ULAUUAUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUU
SH 900.1 (12-03)		
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AVERAGE NUMBER OF EMPLOYEES

ESTABLISHMENT NAME

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

2. EMPLOYENT INFORMATION

1. ESTABLISHMENT INFORMATION

STATE OF NEW YORK DEPARTMENT OF LABOR



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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES

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FORM SH 900.1

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SH 900.1 (12-03)

DATE 2/14/06	MARTINEZ	PRINT NAME SAHUEL
o d l	examined this document and that to the best of my knowledge the entries are true, accurate, and	I certify that I have examined
	6. CERTIFICATION	
HEARING LOSS O ALL OTHER ILLNESSES O O O O O O O O		ABLE CASES (Col. J.)
RESPIRATORY CONDITIONS (Col. 3) POISONINGS (Col. 4)	JOB TRANSFER OR RESTRICTION (Col. L.)	JOB TRANSFER OR RESTRICTION (Col. I.) OTHER RECORD
SKIN DISORDERS	AWAY FROM <u>35</u> WORK (Col. K.)	DEATHS O DAYS AWAY (Cal. G.) FROM WORK 35
5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
73840	< /4 /15 / 15 /	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS)
\mathcal{SH}	1. 10016 fire department)	NDUSTRY DESCRIPTION (e.g., village
AVERAGE NUMBER OF EMPLOYEES		ANE.
2. EMPLOYENT INFORMATION If you don't have accurate figures, see the Instructions on the back of the sheet	INFORMATION	1. ESTABLISHME
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.	Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms	Employees, former employees, and their raits equivalent. See 801.35 and instruction
al iniuries or illnesses occurred during the year.	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.	All establishments covered by Part 801 m
Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240		STATE OF NEW YORK DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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its equivalent. See 801.35 and instructions for nurther details	its equivalent. See 801.35 and instructions for turiner details on access provisions for turine comments of the second se	2. EMPLOYENT INFORMATION
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STREET ADDRESS STARE		AVERAGE NUMBER OF EMPLOYEES
CITY, STATE, ZIP.CODE ATTORNA NY 1/106		14
INDUSTRY DESCRIPTION (e.g., village fire department) NUC DONT DE HEALTH AND NIENTAL HY CIENE	HYDENE	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) $\mathcal{E}_{\mathcal{I}} / / / \mathcal{E}_{\mathcal{I}} / 5 / /$	LASSIFICATION SYSTEM	24500
Enter the column totals from the Log of Occupational Injuries and Illnesses correspond to the columns on the Log). If a category has no cases, enter "0"	Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each category (column labels correspond to the columns on the Log). If a category has no cases, enter "0".	0) for each category (column labels under each line
3. NUMBER OF CASES	4. NUMBER OF DAYS	5. INJURIES AND ILLNESSES TYPES
DEATHS (Col. C.) DAYS AWAY (Col. C.) FROM WORK (Col. H.) JOB TRANSFER	AWAY FROM D WORK (Col. K.)	TINJURIES (Col. 1) SKIN DISORDERS (Col. 1) RESPIRATORY CONDITIONS (Col. 2) (Col. 3)

ADI E CASTO

(Col. I.) C

JOB TRANSFER OR RESTRICTION

0

JOB TRANSFER OR RESTRICTION

(Col. L.) 0

POISONINGS

0

HEALTH DEPT

Fax: 7185383252

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SH 900.1 (12-03)

PRINT NAME

Mary Seabrooks 1 maria

DATE

2/14/2006

I certify that I have examined this document and SIGNATURE Maky Seales 17 Kg			ABLE CASES (Col. J.)	OTHER RECORD- ()	JOB TRANSFER (Col. H.)	DAYS AWAY FROM WORK 0
6. CERTIFICATION i this document and that to the best of my know				(Col. L.)	JOB TRANSFER OR	WORK (Cal. K.)
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. TRE Maky Malch 17 KA TIFLE Clinic Manager		ALL OTHER MUNESSES	HEARING LOSS	POISONINGS (Col. 4)	RESPIRATORY CONDITIONS (Col. 3)	(Col. 2)
, o	AL 0)		5	-4)	Ξ)	1.2)

(NAICS) 9 2 3 1 2 0 561110	INDUSTRY DESCRIPTION (e.g., village fire department) NYC DOH/MH	CITY, STATE, ZIP CODE Bronx, New York 10456	STREET ADDRESS 1309 Fulton Avenue	ESTABLISHMENT NAME Morrisania STD Clinic	1. ESTABLISHMENT INFORMATION	
58,240	TOTAL HOURS WORKE	చ <u></u>	AVERAGE NU	If you don't have Instructions of	2. EMPLOYI	
	total hours worked by all Employbes last year		AVERAGE NUMBER OF EMPLOYEES	If you don't have accurate figures, see the Instructions on the back of the sheet.	2. EMPLOYENT INFORMATION	

Enter the column totals from the Log of Occupational injuries and linesses (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".

DEATHS

0

(Col. G.)

AWAY FROM WORK

SKON DISORDERS

(Col-1)

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NUMBER OF CASES

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NUMBER OF DAYS

(u)

INJURIES AND ILLNESSES TYPES

INJURIES

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Division of Safety and Health Albany NY 12240

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.

DEPARTMENT OF LABOR

STATE OF NEW YORK

/ YORK 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

2005

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
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NYC Dept. Of Health & Mental Hygiene / Bedford Health Center	Instructions on the back of the sheet.
STREET ADDRESS	
485 Throop Avenue	AVERAGE NUMBER OF EMPLOYEES
CITY, STATE, ZIP CODE	
Brooklyn, NY 11221	4
INDUSTRY DESCRIPTION (e.g., village fire department)	
Public Health Clinic	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM	7 600
(MAILS) 923120.	1,000

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".

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ALL OTHER		(Col. J.)		HEARING LOSS
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9 CERTIFICATION

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

DATE TITLE

31/06

Health Services Manager

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SH 900.1 (12-03)

SIGNATURE

PRINT NAME

Kevin McGrath Mecron

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STATE OF NEW YORK DEPARTMENT OF LABOR

PRINT NAME Krista Bringley	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and SIGNATURE With Bringley TITLE Research Assi				ABLE CASES (Col. J.)	0	(Col. H.)	DAYS AWAY (Col. G.) AWAY FROM FROM WORK O WORK	DEATHS O	3. NUMBER OF CASES 4. 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 "θ".	(NAICS) 923120	NYC Dept. of Health and Mental Hygiene	New York, NY 10013	125 Worth Street, Loom 620 CITY, STATE, ZIP CODE	Icial and	1. ESTABLISHMENT INFORMATION	Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred during the year.	I	STATE OF NEW YORK DEPARTMENT OF LABOR
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DATE 2/1/2006	the entries are true, accurate, and complete.		(Col. 6)	LNESSES (Col.	HEARING LOSS O	POISONINGS	RESPIRATORY CONDITIONS O (Col. 3)	SKIN DISORDERS (Col. 2)	INJURIES O (Col. 1)	5. INJURIES AND ILLNESSES TYPES)) for each category (column labels under each line	11,000	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	6	AVERAGE NUMBER OF EMPLOYEES	If you don't have accurate figures, see the Instructions on the back of the sheet.	2. EMPLOYENT INFORMATION	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.	onal injuries or illnesses occurred during the year.	Ω	Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240

STATE OF NEW YORK DEPARTMENT OF LABOR SUMMARY OF LABOR NJURIES AND FORM SH All establishments covered by Part 801 <u>must</u> complete this annually, events is equivalent. See 801.35 and their representatives have the right is equivalent. See 801.35 and instructions for further details on access STREET ADDRESS STREET ADDRESS INDUSTRY DESCRIPTION (e.g., village fire department) NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTE (NAICS) SHIEL EXAMPLATION Enter the column totals from the Log of Occupational Injuries and correspond to the columns on the Log. If a category has no cases.	STATE OF NEW YORK Division of Safety and Health DEPARTMENT OF LABOR SumMARY OF WORK-RELATED State Office Campus State Office Campus Building 12. Room 158 State Office Campus All establishments covered by Part 801 <u>must</u> complete this annually, even if no occupational injuries or illnesses occurred duri Albany NY 12240 All establishments covered by Part 801 <u>must</u> complete this annually, even if no occupational injuries or illnesses occurred duri State Office Campus All establishments covered by Part 801 <u>must</u> complete this annually, even if no occupational injuries or illnesses occurred duri State Office Campus All establishments covered by Part 801 <u>must</u> complete this annually, even if no occupational injuries or illnesses occurred duri State Office Campus State Office Campus State Office Campus State Office Campus State Office Campus State Office Campus State Office Campus State Office Campus State Office Campus State Office Campus State Office Campus State Office Campus State Office Campus State Office Campus Instructions for funder details on access provisions for these forms. If you don't have accurate figures State Tot NAME If you don't have accurate figures If you don't have accurate figures Instructions on the back of the opartm	STATE OF NEW YORK Division of Safety and Health DEPARTMENT OF LABOR Summary of WORK-RELATED Building 12. Room 158 State Office Campus Building 12. Room 158 Albenny NY 12240 State Office Campus State Office Campus Building 12. Room 158 Albenny NY 12240 State Office Campus Building 12. Room 158 State Office Campus Albenny NY 12240 State Office Campus Building 12. Room 158 State Office Campus Albenny NY 12240 State Office Campus Building 12. Room 158 State Office Campus Albenny NY 12240 State Office Campus Building 12. Room 158 State Office Campus Albenny NY 12240 State Office Campus Building 12. Room 158 State Office Campus Albenny NY 12240 State Office Campus Building 12. Room 158 State Office Campus If sequivalent. See 801.35 and instructions for further details on access provisions for these forms. If you don't have accurate figures, see the Instructions on the back of the sheet. State T ADDRESS Albent 1051-1072 1071: Floor If you don't have accurate figures, see the Instructions on the back of the sheet. State T ADDRESS Albent 1051-1072 1071: HEAL DOL AVERAGE NUMBER OF EMPLOYEES Albent York Mark Lag, I of CAUPU A VERAGE NUMBE
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SH 900.1 (12-03)		

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DEATHS (Col. G.) DAYS AWAY FROM WORK (Col. H.) JOB TRANSFER OR RESTRICTION (Col. H.) OTHER RECORD (Col. I.) ABLE CASES (Col. I.)	3. NUMBER OF CASES	Enter the column totals from the Log of correspond to the columns on the Log).	NYC DEPT OF HEALTH & MENTAL 14YG, NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM	CITY, STATE, ZIP CODE <u>New York</u> , <u>NY</u> 10013 INDUSTRY DESCRIPTION (e.g., village fire department)	40 Worth Street	ESTABLISHMENT NAME Bureau of Informatics and Information	1. ESTABLISHMENT INFORMATION	Employees, former employees, and their repits equivalent. See 801.35 and instructions	All establishments covered by Part 801 mu		IATE OF NEW YORK DEPARTMENT OF LABOR
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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
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ESTABLISHMENT NAME Bureaus of Public Health Training-Library	Library	If you don't have accurate figures, see the Instructions on the back of the sheet.
455 First Avenue, 12th Floor, Room 1200	m 1200	AVERAGE NUMBER OF EMPLOYEES
CITY, STATE, ZIP CODE New York, NY 10016		10
INDUSTRY DESCRIPTION (e.g., village fire department) NYC Dept. of Health & Mental Hygiene		TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
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POISONINGS	JOB TRANSFER OR Col. L.)	JOB TRANSFER OR RESTRICTION OTHER RECORD- ARLE CASES
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AVERAGE NUMBER OF EMPLOYEES		MC DOHAMH STREET ADDRESS GG John St. 11 CITY STATE ZIP CODE
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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.	All establishments covered by Part 801 must complete this annually, even if no occupational injun Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	All establishments covered by Part 801 m Employees, former employees, and their r its equivalent. See 801.35 and instruction
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Division of Safety and Health Public Employee Safety and Health Bureau State Office Campus Building 12. Room 158 Albany NY 12240		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

2005

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. 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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130 Nostrand Auc	AVERAGE NUMBER OF EMPLOYEES
CITY, STATE, ZIP CODE	
Brooklyn NY 11205	44
INDUSTRY DESCRIPTION (e.g., village five department)	
RUYC Dept of Health & Mantal Hygin TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).	77 665

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

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JOB TRANSFER OR RESTRICTION (Col. K) AWAY FROM (Col. K) WORK (Col. L)	4. NUMBER OF DAYS
INJURIES	5. INJURIES AND ILLNESS TYPES

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

SH-900.1 (2-03)

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	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	ED
All establishments covered by Part 801 m	All establishments covered by Part 801 must complete this annually, even if no occupational injuries or illnesses occurred	ional injuries or illnesses occurred during the year.
Employees, former employees, and their r its equivalent. See 801.35 and instruction	Employees, former employees, and their representatives have the right to review this form. They a its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	lso have limited access
1. ESTABLISHMENT INFORMATION	INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Policy, Planning, Quality & Develc	Development-Dept. of Health/Hygiene	If you don't have accurate figures, see the Instructions on the back of the sheet.
125 Worth Street 6th Floor Room 627	627	AVERAGE NUMBER OF EMPLOYEES
CITY, STATE, ZIP CODE		
New York, NY 10013		σ
INDUSTRY DESCRIPTION (e.g., village fire department)		
NORTH AMERICAN INDUSTRIAL OF A SOFTICA THOM SUSTAIN		TO THE HOURS WORKED BI ALL EMPLOYEES LAST YEAK
(NAICS) 9 9 3		8,400
Enter the column totals from the Log of correspond to the columns on the Log).	Occupational Injuries and Illnesses (SH 900 If a category has no cases, enter "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 ILLNESSES TYPES
DEATHS 0		INJURIES 0 (Col. 1)
(Col. G.) FROM WORK 0	AWAY FROM 0 WORK (Col. K.)	SKIN DISORDERS 0 (Col. 2)
JOB TRANSFER (Col. H.) OR RESTRICTION 0	JOB TRANSFER OR	RESPIRATORY CONDITIONS 0 (Col. 3)
(Col. I.) ABLE CASES 0	0	POISONINGS 0 (Col. 4)
(Col. J.)		HEARING LOSS 0
		ALL OTHER ILLNESSES (Col. 5) (Col. 6)
	6. CERTIFICATION	
I certify that I have examined the SIGNATURE	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate,	dge the entries are true, accurate, and complete.
PRINT NAME Dan Lehman		DATE Feb. 7, 06
SH 900.1 (12-03)	-	

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

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DATE 1/31/06	D. SHITH	PRINT NAME TONI
I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. $RE \qquad \mathcal{O} \ \kappa_i \ \mathcal{O} \ \mathcal{O} \ \kappa_i \ \mathcal{O} \ \mathcal{O} \ \kappa_i \ \mathcal{O} \ \mathcalO \ $	this document and that to the best of my knowle $\mathcal{O}m_i$ \mathcal{H}_j	I certify that I have examined SIGNATURE
	6. CERTIFICATION	
ALL OTHER ILLNESSES (Col. 6)		
HEARING LOSS		(Col. J.)
POISONINGS (Col. 4)	(Col. L.)	OTHER RECORD- (Col. I.)
RESPIRATORY CONDITIONS (Col. 3)	JOB TRANSFER OR	JOB TRANSFER (Col. H.)
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INJURIES /		DEATHS
5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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".	f Occupational Injuries and Illnesses (SH 900 If a category has no cases, enter "0".	Enter the column totals from the Log correspond to the columns on the Log)
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10	29	NEW 46 R 12 100 100 100 100 100 100 100 100 100
AVERAGE NUMBER OF EMPLOYEES	ET ROOM 222	158 E 115 STREET CITY, STATE, ZIP CODE
If you don't have accurate figures, see the Instructions on the back of the sheet.	DOHMH - RETONT	ESTABLISHMENT NAME NY CDOHM ORACHEALTH PROGRAMS & POLICY MANHATTAN REGIONAL OFFICE STREET ADDRESS
2. EMPLOYENT INFORMATION	T INFORMATION	1. ESTABLISHMENT INFORMATION

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.

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1 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

	IM SH-900.1 ary annually, even if no occupational injuries or illnesses occurred during the year ht to review this form. They also have limited access to the Log (SH 900) or its equiver these forms. Image: state of the log (SH 900) or its equiver these forms. Image: state of the log (SH 900) or its equiver these forms. Image: state of the log (SH 900) or its equiver the
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RLEASE NOTE: CENTER CLOSED SEPTEMBER 2, 2005 6. CERTIFICATION I certify that I have examined this document and that to the best of my knowledge the entries are true, SIGNATURE MINUNAN. TITLE Admin.	$\frac{11692}{\text{ICS}}, \frac{8}{\text{ITTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR}} \\ \frac{8}{\text{ICS}}, \frac{2}{\text{ITTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR}} \\ \frac{11692}{\text{ICS}}, \frac{2}{\text{ICS}}, \frac{2}$
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6. CERTIFICATION		JOB TRANSFER OR RESTRICTION	AWAY FROM WORK	4. NUM
kn 9			(са к)	4. NUMBER OF DAYS
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. TRE $\frac{1}{10000000000000000000000000000000000$	HEARING LOSS (Col. 5) ALL OTHER ILLNESSES (Col. 6)	RESPIRATORY CONDITIONS	INJURIES $(C_{0}, 1)$ SKIN DISORDERS $(C_{0}, 2)$	5. INJURIES AND ILLNESSES TYPES

(NAICS) CIT STREET ADDRESS ESTABLISHMENT NAME NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM DUS LATE, Dunc 1 ZIP RIPTION n 0210 CODE w ANCE (e.g.. 220 VIIIa te ge fire department) f Chu cotton And 000 1 RAMNA TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR If you don't have accurate figures, see the Instructions on the back of the sheet. AVERAGE NUMBER OF EMPLOYEES 060

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".

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

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

SUMMARY OF WORK-RELATED Public Employee Safety and Health Bureau

DEPARTMENT OF LABOR STATE OF NEW YORK

		Building 12. Room 158 Albany NY 12240
	SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1	
All establishments covered by Part 801 mus	\underline{t} complete this annually, even if no occupation	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 reprits equivalent. See 801.35 and instructions f	resentatives have the right to review this form. or further details on access provisions for these	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	NFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME NYCDOHMH-BMIRH-NEWBORN		If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 158 E 115TH STREET		AVERAGE NUMBER OF EMPLOYEES
CITY, STATE, ZIP CODE		ס
NEW YORK, NY 10029		
NDUSTRY DESCRIPTION (e.g., vinage me uepar unem) NYCDOHMH		TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM	ASSIFICATION SYSTEM	10,290
021110,020120		
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3. NUMBER OF CASES	4. NOMBEN OF BALS	INJURIES $\frac{0}{(Col. 1)}$
DEATHS U DAYS AWAY Col. G.)	AWAY FROM 0 WORK (Col. K.)	SKIN DISORDERS $\frac{0}{(Col. 2)}$
JOB TRANSFER 0	JOB TRANSFER OR	RESPIRATORY CONDITIONS $\frac{0}{(Col. 3)}$
		POISONINGS <u>(Col. 4)</u>
ABLE CASES (Col. J.)		HEARING LOSS $\frac{0}{0}$
		(Col. 6)
	6. CERTIFICATION	
I certify that I have examined t	this document and that to the best of my knowl	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.
HAYW	INEY, JR	DATE 3/16/06
SH 900.1 (12-03) Drogram	WAS located @ 22	38 St Ave
1.tur	10/05	



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

All establishments covered by Part 801 mu	st complete this annually, even if no occupation	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 repits equivalent. See 801.35 and instructions	Employees, former employees, and their representatives have the right to review this form. They also have limited access its equivalent. See 801.35 and instructions for further details on access provisions for these forms.	n. They also have limited access to the Log (SH-900) or ese forms.
1. ESTABLISHMENT INFORMATION	INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME NUC DO	REPRODUCTIVE HEALTH - COMMUNITY EDUCATIONAL SERVICES	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 25 Chapel	Street 10th A. Suite 1006	
Brooklyn	NY 11201	AVERAGE NUMBER OF EMPLOYEES
CITY, STATE, ZIP CODE		00
INDUSTRY DESCRIPTION (e.g., village fire department)		TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS)	LASSIFICATION SYSTEM	14,560
Enter the column totals from the Log of Occupational Injuries and Illnesses correspond to the columns on the Log). If a category has no cases, enter "0"	Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each category (column la correspond to the columns on the Log). If a category has no cases, enter "0".	0) for each category (column labels under each line
3. NUMBER OF CASES	4. NUMBER OF DAYS	5. INJURIES AND ILLNESSES TYPES
DEATHS (Col. G.) DAYS AWAY (Col. G.) FROM WORK	AWAY FROM <u>84</u> WORK (Col. K.)	INJURIES (Col. 1) SKIN DISORDERS (Col. 2)
	JOB TRANSFER OR RESTRICTION (Col. L.)	RESPIRATORY CONDITIONS (Col. 3) POISONINGS (Col. 4)
ABLE CASES (Col. J.)		HEARING LOSS (Col. 5) ALL OTHER ILLNESSES (Col. 6)
	6. CERTIFICATION	
I certify that I have examined t	in document and that to the best of my knowl	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.
PRINT NAME NAOMI GI	GRACIA	DATE 3-22-06
SH 900.1 (12-03)		



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

3. NUMBER OF CASES	4. NUMBER OF DAYS	5. INJURIES AND ILLNESSES TYPES	S
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		ALL OTHER ILLNESSES $\frac{0}{(c)}$	(Col. 6)
UC -	6. CERTIFICATION		
I certify that I have examined	I certify that I have, examined this document and that to the best of my knowledge the entries are frue, accurate, and	edge the entries are true, accurate, and complete.	ste.
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PRINT NAME / UCZUDY	Ill topors	DATE //26/06	
SH 900.1 (12-03)		/ /	

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".

Jackson Heights, N.Y. 11372

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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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

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TITLE (TENCE & JONNO V (1 20)	(Malan)	SIGNATURE JUNK
owledge the entries are true, accurate, and complete.	I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and	I certify that I have examine
2	6. CERTIFICATION	
ALL OTHER ILLNESSES 0 (Col. 6)		
HEARING LOSS $\frac{0}{(Col.5)}$		ABLE CASES 2 (Col. J.)
POISONINGS 0 (Col. 4)	RESTRICTION (Col. L.)	OR RESTRICTION (Col. I.)
RESPIRATORY CONDITIONS $\frac{0}{(Col. 3)}$	JOB TRANSFER OR	
SKIN DISORDERS 0 (Col. 2)	AWAY FROM 191 WORK (Col. K.)	DEATHS U (Col. G.) DAYS AWAY
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5. INJURIES AND ILLNESSES TYPES	4. NUMBER OF DAYS	3. NUMBER OF CASES
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".	f Occupational Injuries and Illnesses (SH If a category has no cases, enter "0".	Enter the column totals from the Log of correspond to the columns on the Log).
		(NAICS) 923120/621399
50750	LASSIFICATION SYSTEM	NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM
TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR	ge fire department)	INDUSTRY DESCRIPTION (e.g., village fire department) HEALTH DEPARTMENT
		JAMAICA, N.Y. 11432
29		CITY, STATE, ZIP CODE
AVERAGE NUMBER OF EMPLOYEES		90-37 Parson's Blvd.
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If you don't have accurate figures, see the		ESTABLISHMENT NAME
2. EMPLOYENT INFORMATION	INFORMATION	1. ESTABLISHMENT INFORMATION

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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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

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STATE OF NEW YORK DEPARTMENT OF LABOR