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

2004

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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

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

1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: ORAL HEALTH PROGRAMS & POLICY FOR NEW YORK CITY	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: BUSHWICK HEALTH CENTER - DENTAL CLINIC 335 CENTRAL AVE.	AVERAGE NUMBER OF EMPLOYEES: 14
CITY, STATE, ZIP CODE: BROOKLYN, NEW YORK, N.Y. - 11221	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 6,923
INDUSTRY DESCRIPTION (e.g.. village fire department): NEW YORK CITY DOH MH	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 621210	

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

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

6. CERTIFICATION

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

SIGNATURE: Stephens R. Kumar TITLE: REGIONAL ADMINISTRATIVE DIRECTOR

PRINT NAME: STEPHENS R. KUMAR DATE: 1/21/2005

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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

2004

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: EARN Intervention Program / Child Fatality Unit

STREET ADDRESS: 40 Worth Street Rm 1607

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

INDUSTRY DESCRIPTION (e.g., village fire department): N.Y.C. DoHMH

STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN (NAICS): 923120, 624190

2. EMPLOYMENT INFORMATION

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

AVERAGE NUMBER OF EMPLOYEES: 34

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 64073

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

3. NUMBER OF CASES

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

4. NUMBER OF DAYS

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

5. INJURIES AND ILLNESS TYPES

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

6. CERTIFICATION

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

SIGNATURE: Deborah Adams

TITLE: Coordinating Manager

PRINT NAME: Deborah Adams

DATE: 1/26/05

SH-900.1 (12-02)

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Operations Riverside Health Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 160 West 100 Street	AVERAGE NUMBER OF EMPLOYEES 6
CITY, STATE, ZIP CODE New York, N.Y. 10025	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 10,750
INDUSTRY DESCRIPTION (e.g., village fire department) N.Y.C. Dept. of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 561720	

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

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

6. CERTIFICATION

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

SIGNATURE Norbert Afaandl TITLE Health Services Mgr

PRINT NAME NORBERT ATAANDE DATE 1/28/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
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Albany NY 12240

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Dept. of Health Pest. Control	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 51 Stuyvesant Place	AVERAGE NUMBER OF EMPLOYEES: 15
CITY, STATE, ZIP CODE: Staten Island, N.Y. 10301	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 26,860
INDUSTRY DESCRIPTION (e.g.. village fire department): N.Y.C. Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 561710-561110-488490	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 NONE (Col. G.)	AWAY FROM WORK	0 (Col. K.)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE: Curtis Brenner TITLE: Sr Crew Chief

PRINT NAME: CURTIS BRENNER DATE: 1-21-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Immunization – CROWN HEIGHTS H.C.	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 1218 PROSPECT PL, 1ST FLOOR	AVERAGE NUMBER OF EMPLOYEES 7
CITY, STATE, ZIP CODE BROOKLYN NY 11213	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 12,005
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE _____ **TITLE** Staff Analyst

PRINT NAME Robert Young **DATE** 1-31-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Tuberculosis Control-Chelsea Chest Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 303 9th Avenue, 3rd Floor	AVERAGE NUMBER OF EMPLOYEES 18
CITY, STATE, ZIP CODE New York, NY 10001	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 30,870
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 621399	

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

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

6. CERTIFICATION

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

SIGNATURE JRamlakhan for Clifford Johnson **TITLE** Clinic Manager

PRINT NAME CLIFFORD JOHNSON. **DATE** 1-31-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME BUREAU OF STD CONTROL - FT. GREENE H.C.	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 295 FLATBUSH AVE. EXT., 4th FLOOR	AVERAGE NUMBER OF EMPLOYEES 27
CITY, STATE, ZIP CODE BKlyn N.Y. 11201	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC DEPT. OF HEALTH & MENTAL HYGIENE	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 45,360
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 621399, ____ ____	

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

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

6. CERTIFICATION

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

SIGNATURE Lucenda Williams TITLE Clinic Manager

PRINT NAME Lucenda Williams DATE 3/7/05

SH 900.1 (12-03)

STATE OF NEW YORK
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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Bureau of STD CONTROL - RIVERSIDE H.C.	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 160 West 100th St, Rm 145	AVERAGE NUMBER OF EMPLOYEES: 26
CITY, STATE, ZIP CODE: N.Y. N.Y 10025	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 44,590
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept of Health Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120, 621399	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	7 (Col. K.)	INJURIES	1 (Col. 1)
DAYS AWAY FROM WORK	1 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE: Geneva Brickhouse TITLE: Ass Staff Analyst

PRINT NAME: GENEVA BRICKHOUSE DATE: 1/21/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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2004

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N/A

1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Bureau of STD Control - Morrisania H.C.	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 1309 Fulton Avenue, 2nd Fl	AVERAGE NUMBER OF EMPLOYEES: 34
CITY, STATE, ZIP CODE: Bronx, NY 10456	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 58,870
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Mary Seabrooks TITLE Clinic Manager

PRINT NAME Mary Seabrooks DATE 1/29/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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Public Employee Safety and Health Bureau
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2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Operations-Health Police Central DOHMH Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 Worth Street, 1st Floor	AVERAGE NUMBER OF EMPLOYEES 12
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 24,416.
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 922120	

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

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

6. CERTIFICATION

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

SIGNATURE Christine C Baucom **TITLE** Deputy Chief

PRINT NAME Christine Baucom **DATE** 1-31-05

SH 900.1 (12-03)

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DEPARTMENT OF LABOR

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Operations-Health Police Labs	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 455 1st Avenue, 1st Floor	AVERAGE NUMBER OF EMPLOYEES 18
CITY, STATE, ZIP CODE New York, NY 10016	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 36,416
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 922120	

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

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

6. CERTIFICATION

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

SIGNATURE Christine Baucom TITLE Deputy Chief

PRINT NAME Christine Baucom DATE 1-31-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Equal Employment Opportunity Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 93 Worth Street, Room 1114B	AVERAGE NUMBER OF EMPLOYEES 4
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 6860
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561110	

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

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

6. CERTIFICATION

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

SIGNATURE IRamlakhan **TITLE** Health & Safety Compliance Inspector

PRINT NAME Ingrid Ramlakhan **DATE** 1/31/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Public Health Training & Injury Epidemiology	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 2 Lafayette Street, 20th floor	AVERAGE NUMBER OF EMPLOYEES: 24
CITY, STATE, ZIP CODE: New York N.Y. 10007	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 37500
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC- Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120, 561110	

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

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

6. CERTIFICATION

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

SIGNATURE Delores Sands TITLE PHD

PRINT NAME Deloris Sands DATE 2/2/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Public Health Library	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 455 1st Avenue - 12th floor	AVERAGE NUMBER OF EMPLOYEES: 10
CITY, STATE, ZIP CODE: New York N.Y. 10016	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 9800
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept. of Health + mental Hygene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 561110	

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

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

6. CERTIFICATION

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

SIGNATURE DeLores Sands TITLE PHO

PRINT NAME Delores Sands DATE 2/2/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Office of Environmental Investigations	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 2 Lafayette Street, 11th Floor	AVERAGE NUMBER OF EMPLOYEES 11
CITY, STATE, ZIP CODE New York, NY 10007	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 20,590
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 541620, 923120, 541990	

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

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

6. CERTIFICATION

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

SIGNATURE Ramlakhan for Ray Nieves TITLE Health & Safety Compliance Officer

PRINT NAME Ray Nieves/Ingrid Ramlakhan DATE 4/29/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Operations - Brownsville Health Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 259 Bristol Street, Room 344 & Basement	AVERAGE NUMBER OF EMPLOYEES 4
CITY, STATE, ZIP CODE Brooklyn, NY 11212	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 7,595
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 561720	

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

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

6. CERTIFICATION

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

SIGNATURE Ricardo M. Baker **TITLE** Administrative Manager

PRINT NAME Ricardo M. Baker **DATE** 1-31-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of HIV/AIDS- HIV Epidemiology Program	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 346 Broadway, Rooms 701-707	AVERAGE NUMBER OF EMPLOYEES 113
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 193,200
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 621330, 561110	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	42 (Col. K.)	INJURIES	3 (Col. 1)
DAYS AWAY FROM WORK	3 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE  TITLE Public Health Epidemiologist II

PRINT NAME Peter Rosas DATE 5/2/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
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Albany NY 12240

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Division of Environmental Health-Administrative Offices	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 Worth Street, Rooms 613-616	AVERAGE NUMBER OF EMPLOYEES 16
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 25,790
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 541620	

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

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

6. CERTIFICATION

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

SIGNATURE Meredith Laureno TITLE Staff Analyst

PRINT NAME Meredith Laureno DATE 1-31-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
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Albany NY 12240

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bur. School Health- Region 3 / Brooklyn East	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 1601 Ave S. Rm 245	AVERAGE NUMBER OF EMPLOYEES 222
CITY, STATE, ZIP CODE Brooklyn NY 11229	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 272,076
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 624110, 621399, 923120	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	Ø (Col. G.)	AWAY FROM WORK	217 (Col. K.)	INJURIES	4 (Col. 1)
DAYS AWAY FROM WORK	3 (Col. H.)	JOB TRANSFER OR RESTRICTION	Ø (Col. L.)	SKIN DISORDERS	Ø (Col. 2)
JOB TRANSFER OR RESTRICTION	Ø (Col. I.)			RESPIRATORY CONDITIONS	Ø (Col. 3)
OTHER RECORD-ABLE CASES	1 (Col. J.)			POISONINGS	Ø (Col. 4)
				HEARING LOSS	Ø (Col. 5)
				ALL OTHER ILLNESSES	Ø (Col. 6)

6. CERTIFICATION

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

SIGNATURE Valerie Valmont TITLE Assoc. Staff. Analyst

PRINT NAME Valerie Valmont DATE 1-27-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Operations - Facility Planning & Plant Operations	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 2 Lafayette Street, 18th Floor	AVERAGE NUMBER OF EMPLOYEES: 16
CITY, STATE, ZIP CODE: New York, NY 10007	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 32,130
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept. of Health - Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 541310	

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

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

6. CERTIFICATION

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

SIGNATURE: Christine Abril TITLE: PAA

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

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Human Resources - Employee Health Program	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 303 9th Avenue Rm 034	AVERAGE NUMBER OF EMPLOYEES 8
CITY, STATE, ZIP CODE New York NY 10001	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 13,505
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 621112 621399	

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

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

6. CERTIFICATION

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

SIGNATURE IRamlakhan **TITLE** Health & Safety Compliance Inspector

PRINT NAME INGRID RAMLAKHAN **DATE** 1/31/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Environmental Health-Regulatory Quality Assurance	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 40 Worth Street, 15th Floor	AVERAGE NUMBER OF EMPLOYEES 16
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 27685
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561110, 518210	

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

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

6. CERTIFICATION

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

SIGNATURE Georgia Davidson TITLE Director

PRINT NAME Georgia Davidson DATE 4/27/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
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2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Vital Statistics	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 Worth Street, Floors 1, 2 & B	AVERAGE NUMBER OF EMPLOYEES 162
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 275,765
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561110, 541990	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	**AWAY FROM WORK**	14 (Col. K.)	**INJURIES**	2 (Col. 1)
DAYS AWAY FROM WORK	2 (Col. H.)	**JOB TRANSFER OR RESTRICTION**	0 (Col. L.)	**SKIN DISORDERS**	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			**RESPIRATORY CONDITIONS**	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			**POISONINGS**	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Jean Jacobs **TITLE** Program Management Officer

PRINT NAME Jean Jacobs **DATE** 1-31-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME HPDP- Brooklyn District Public Health Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 335 Central Avenue, 1st Floor	AVERAGE NUMBER OF EMPLOYEES 18
CITY, STATE, ZIP CODE Brooklyn, NY 11221	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 28672
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120	

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

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

6. CERTIFICATION

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

SIGNATURE Ramlakhan for Joanne Alexis. TITLE Health & Safety Officer

PRINT NAME Joanne Alexis/Ingrid Ramlakhan DATE 5/4/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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

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

1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME FSM-Business Systems Improvement	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 93 Worth Street, Room 700	AVERAGE NUMBER OF EMPLOYEES 7
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 12,250
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561110	

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

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

6. CERTIFICATION

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

SIGNATURE IRamlakhan for Madeline Colon TITLE Health & Safety Officer

PRINT NAME Madeline Colon/Ingrid Ramlakhan DATE 5/4/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Correctional Health Services-Vernon C. Bain Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 1 Halleck Street Bronx 10474	AVERAGE NUMBER OF EMPLOYEES 25
CITY, STATE, ZIP CODE Bronx, NY 10474	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 39,690
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 621111, 621399, 623990	

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

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

6. CERTIFICATION

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

SIGNATURE Ramlakhan for Michael Aragon TITLE Health & Safety Officer

PRINT NAME Ingrid Ramlakhan/Michael Aragon DATE 5/10/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Correctional Health Services-Bernard B. Kerik Complex	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 White Street	AVERAGE NUMBER OF EMPLOYEES 6
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 6,615
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 621111, 621399, 623990	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	**AWAY FROM WORK**	0 (Col. K.)	**INJURIES**	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H.)	**JOB TRANSFER OR RESTRICTION**	0 (Col. L.)	**SKIN DISORDERS**	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			**RESPIRATORY CONDITIONS**	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			**POISONINGS**	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	8 (Col. 6)

6. CERTIFICATION

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

SIGNATURE IRamlakhan for Michael Aragon **TITLE** Health & Safety Officer

PRINT NAME Ingrid Ramlakhan/Michael Aragon **DATE** 5/10/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME 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 NUMBER OF EMPLOYEES 100
CITY, STATE, ZIP CODE New York, NY 10007	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 168,560
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 621399, 561110	

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

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

6. CERTIFICATION

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

SIGNATURE Ramlakhan for Michael Aragon **TITLE** Health & Safety Officer

PRINT NAME Ingrid Ramlakhan/Michael Aragon **DATE** 5/10/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Correctional Health- Warehouse	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 18-39 42nd Street	AVERAGE NUMBER OF EMPLOYEES 22
CITY, STATE, ZIP CODE Astoria, NY 11105	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 38,955
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 493110, 492210	

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

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

6. CERTIFICATION

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

SIGNATURE Ramlakhan for Michael Paul **TITLE** Health & Safety Officer

PRINT NAME Ingrid Ramlakhan/Michael Paul **DATE** 5/9/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of STD Control-Administration/Central Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 Worth Street, Rooms 207 & 212	AVERAGE NUMBER OF EMPLOYEES 53
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 90,755
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Linda Brown **TITLE** Program Planner

PRINT NAME Linda Brown **DATE** 3/4/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of STD Control- Jamaica HC	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 90-37 Parsons Boulevard, 1st Floor	AVERAGE NUMBER OF EMPLOYEES 32
CITY, STATE, ZIP CODE Jamaica, NY 11432	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 54,880
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Ramlakhan for Cynthia Martinez TITLE Health & Safety Officer

PRINT NAME Ingrid Ramlakhan/Cynthia Martinez DATE 5/9/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Bureau of School Health Region IV	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 151 MAUJER Street, 3rd fl.	AVERAGE NUMBER OF EMPLOYEES: 238
CITY, STATE, ZIP CODE: BROOKLYN NY 11206	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 350,210
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120; 621111; 621399	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	44 (Col. K.)	INJURIES	4 (Col. 1)
DAYS AWAY FROM WORK	3 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORDABLE CASES	1 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Joan Rondon TITLE Regional Nursing Director

PRINT NAME JOAN RONDON DATE 5/9/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Day Care-Enforcement Unit	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 151 Maujer Street, Floors 1 & Basement	AVERAGE NUMBER OF EMPLOYEES 31
CITY, STATE, ZIP CODE Brooklyn, NY 11206	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 54,180
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 624110	

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

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

6. CERTIFICATION

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

SIGNATURE Ramlakhan for Lana Reid **TITLE** Health & Safety Officer

PRINT NAME Ingrid Ramlakhan/Lana Reid **DATE** 5/9/05

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of S.T.D. Control - Central Harlem	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 2238 Fifth Avenue, 3rd Floor	AVERAGE NUMBER OF EMPLOYEES 32
CITY, STATE, ZIP CODE New York, NY 10037	
INDUSTRY DESCRIPTION (e.g.. village fire department) N.Y.C. Department of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 54,880
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Aurea Hernandez TITLE Associate Staff Analyst

PRINT NAME Ms. Aurea Hernandez DATE 5/9/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Day Care-Group Day Care Queens	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 120-34 Queens Boulevard, 4th Floor	AVERAGE NUMBER OF EMPLOYEES 13
CITY, STATE, ZIP CODE Kew Gardens, NY 11424	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 20,531
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 624110	

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

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

6. CERTIFICATION

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

SIGNATURE IRamlakhan for Patricia Ogundele **TITLE** Health & Safety Officer

PRINT NAME Ingrid Ramlakhan/Patricia Ogundele **DATE** 5/9/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
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2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Day Care-Family Day Care Manhattan	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 160 West 100 Street, Floors 2 & 3	AVERAGE NUMBER OF EMPLOYEES 24
CITY, STATE, ZIP CODE New York, NY 10025	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 39,935
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 624110	

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

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

6. CERTIFICATION

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

SIGNATURE Ramlakhan for Andrea Batts **TITLE** Health & Safety Officer

PRINT NAME Ingrid Ramlakhan/Andrea Batts **DATE** 5/9/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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

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

1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME HPDP-Bureau of Minority Health	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 485 Throop Avenue, Room 1102	AVERAGE NUMBER OF EMPLOYEES 7
CITY, STATE, ZIP CODE Brooklyn, New York 11221	
INDUSTRY DESCRIPTION (e.g.. village fire department) New york City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 12,005
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120	

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

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

6. CERTIFICATION

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

SIGNATURE Ramlakhan for Victor Hunter **TITLE** Health & Safety Officer

PRINT NAME Ingrid Ramlakhan/Victor Hunter **DATE** 4/29/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Correctional Health Services-Rikers Island (all units)	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 16-06 Hazen Street (West Facility Trailer)	AVERAGE NUMBER OF EMPLOYEES 125
CITY, STATE, ZIP CODE Elmhurst, NY 11377	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 219,275
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 621111, 621399, 623990	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	**AWAY FROM WORK**	28 (Col. K.)	**INJURIES**	4 (Col. 1)
DAYS AWAY FROM WORK	4 (Col. H.)			**SKIN DISORDERS**	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)	**JOB TRANSFER OR RESTRICTION**	0 (Col. L.)	**RESPIRATORY CONDITIONS**	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			**POISONINGS**	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Ramlakhan for Michael Aragon **TITLE** Health & Safety Officer

PRINT NAME Ingrid Ramlakhan/Michael Aragon **DATE** 5/10/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Bureau of STD Control (EAST Harlem)	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 158 E 115th St, 1 Floor	AVERAGE NUMBER OF EMPLOYEES: 11
CITY, STATE, ZIP CODE: NYC NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 19,250
INDUSTRY DESCRIPTION (e.g.. village fire department): Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 621111 621399	

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

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

6. CERTIFICATION

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

SIGNATURE: Maria Rodriguez TITLE: DIS/SW PHA

PRINT NAME: Maria Rodriguez DATE: 1/18/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Richmond Health Center.	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 51 Stuyvesant Place.	AVERAGE NUMBER OF EMPLOYEES: 4
CITY, STATE, ZIP CODE: Staten Island, N.Y. 10301	
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept of Health Dental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 1,000.
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 561720	

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

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

6. CERTIFICATION

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

SIGNATURE Karen S Goldberg TITLE Building Mgr.

PRINT NAME KAREN S. Goldberg DATE 1-31-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Bureau of TB Control / H. Greene Chest Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 345 Nathan Avenue Ext. 3rd Floor	AVERAGE NUMBER OF EMPLOYEES: 43
CITY, STATE, ZIP CODE: Brooklyn NY 11201	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 77,000
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE: Carrie Williams TITLE: PCM

PRINT NAME: Carrie Williams DATE: 1/18/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of TB Control - Epi / Surveillance Unit	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 346 Broadway, Rm 831	AVERAGE NUMBER OF EMPLOYEES 40
CITY, STATE, ZIP CODE New York NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 72,800
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Sheryl V. Butler TITLE Network Director

PRINT NAME Sheryl V. Butler DATE 1-14-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
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Albany NY 12240

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: HPDP – Bureau of Tobacco Control	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 2 Lafayette St. 21st	AVERAGE NUMBER OF EMPLOYEES: 23
CITY, STATE, ZIP CODE: New York, NY 10007	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 37,513
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept. of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Deiderie Armstrong TITLE Health & Safety OFFICE

PRINT NAME Deiderie Armstrong DATE 1/31/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
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Albany NY 12240

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of TB Control Bushwick Chest Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 335 CENTRAL Ave 2nd FLOOR	AVERAGE NUMBER OF EMPLOYEES 9
CITY, STATE, ZIP CODE BROOKLYN, N.Y. 11221	
INDUSTRY DESCRIPTION (e.g., village fire department) NYC Dept. of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 15,435
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE [signature] TITLE PAA I

PRINT NAME ROBIN L. COLEMAN DATE 1-18-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Bureau of TB Control, Homeless Services Unit	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 1372 Bedford Avenue	AVERAGE NUMBER OF EMPLOYEES: 1
CITY, STATE, ZIP CODE: Brooklyn, N.Y. 11216	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 2,100
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept. of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE nikolaos mitropoulos TITLE Associate Staff Analyst

PRINT NAME NIKOLAOS MITROPOULOS DATE 10 Jan. 2005

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of TB Control, Homeless Services Unit	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 400-430 East 30th St. N.Y. N.Y. 10016	AVERAGE NUMBER OF EMPLOYEES Eight (8)
CITY, STATE, ZIP CODE New York, N.Y. 10016	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 72,800
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE nikolaos mitropoulos TITLE Associate Staff Analyst

PRINT NAME NIKOLAOS MITROPOULOS DATE 7 January 2005

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Operations Morrisania Health Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 1309 Fulton Avenue Rm 302 & B - Executive Office	AVERAGE NUMBER OF EMPLOYEES 4
CITY, STATE, ZIP CODE Bronx NY 10456	
INDUSTRY DESCRIPTION (e.g., village fire department) NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 8292
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 561720	

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

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

6. CERTIFICATION

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

SIGNATURE Valerie Bailey TITLE Health Services Manager

PRINT NAME Valerie Bailey DATE 1/20/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
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2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME (Staten Is Office) EARLY INTERVENTION	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 2971 Hylan Blvd.	AVERAGE NUMBER OF EMPLOYEES 11
CITY, STATE, ZIP CODE Staten Island, N.Y. 10306	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC DOHMH	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 20,925
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 624190	

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

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

6. CERTIFICATION

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

SIGNATURE Loretta J. Ashworth TITLE Coordinating Manager

PRINT NAME LORETTA J. ASHWORTH DATE 1-21-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

2004

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

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

1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of School Health-Central office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 2 Lafayette St. 22nd floor	AVERAGE NUMBER OF EMPLOYEES 30
CITY, STATE, ZIP CODE N.Y., N.Y. 10007	
INDUSTRY DESCRIPTION (e.g.. village fire department) N.Y.C. of Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 51,450
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 624110, 621111, 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Karen Adams TITLE Asst to Asst Commissioner

PRINT NAME Karen Adams DATE March 9, 2005

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Financial & Strategic Mgmt Office of Payroll	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 253 Broadway Room #400	AVERAGE NUMBER OF EMPLOYEES 48
CITY, STATE, ZIP CODE New York, NY 10007	
INDUSTRY DESCRIPTION (e.g., village fire department) New York City Department of Health + Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 86,320
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 541214	

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

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

6. CERTIFICATION

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

SIGNATURE Laila Salib TITLE Director

PRINT NAME LAILA SALIB DATE 3/15/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Commissioner's Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 125 Worth St. Rm 331	AVERAGE NUMBER OF EMPLOYEES: 17
CITY, STATE, ZIP CODE: New York, NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 35,219
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept. of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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

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

6. CERTIFICATION

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

SIGNATURE: Gloria Murphy TITLE: PMO

PRINT NAME: GLORIA MURPHY DATE: 03/14/2005

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: ORAL HEALTH PROGRAMS AND POLICY	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 1932 ARTHUR AVE. RM 403B *	AVERAGE NUMBER OF EMPLOYEES: 24
CITY, STATE, ZIP CODE: BRONX, NY 10457	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 36,340
INDUSTRY DESCRIPTION (e.g., village fire department): NYC DOHMH	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 621210 923120	

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

* EMPLOYEES ARE BASED AT VARIOUS SCHOOL SITES

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

6. CERTIFICATION

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

SIGNATURE: Mark Lewis TITLE: REGIONAL DIRECTOR

PRINT NAME: MARK LEWIS DATE: 1/5/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of TB Control Bedford Chest Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 485 Throop Avenue, Bsmt 2nd & 3rd Fl	AVERAGE NUMBER OF EMPLOYEES 60
CITY, STATE, ZIP CODE Brooklyn N.Y 11221	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 98,000
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 621399, 923120	

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

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

6. CERTIFICATION

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

SIGNATURE David T. Cappell TITLE Center Administrative Manager

PRINT NAME David T. Cappell DATE 1/05/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Bureau of Emergency Management	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 125 Worth Street Rm 326	AVERAGE NUMBER OF EMPLOYEES: 6
CITY, STATE, ZIP CODE: New York, NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 10 290
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC DOHMH	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	0 (Col. K.)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	8 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Marisa Raphael TITLE Deputy Director

PRINT NAME MARISA RAPHAEL DATE 2/2/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Environmental Health Manhattan Pest Control Services	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 158 East 115 st. Rm 209A & Basement	AVERAGE NUMBER OF EMPLOYEES 50
CITY, STATE, ZIP CODE New York, N.Y. 10029	
INDUSTRY DESCRIPTION (e.g., village fire department) Dept. of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 36,400
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561710, 561110, 488490	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	20 (Col. K.)	INJURIES	3 (Col. 1)
DAYS AWAY FROM WORK	3 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORDABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Caroline Hilton TITLE Regional Director

PRINT NAME Caroline Hilton DATE 2-1-2005

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME DIVISION OF MENTAL HYGIENE ADMINISTRATION & BORO OFFICES*	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 93 WORTH STREET FLOORS 1-12	AVERAGE NUMBER OF EMPLOYEES 207
CITY, STATE, ZIP CODE NEW YORK, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) MUNICIPAL CITY AGENCY	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 355,005 hrs
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 561110	

* ALL BORO OFFICES RELOCATED TO 93 WORTH STREET

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

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

6. CERTIFICATION

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

SIGNATURE Paula Savarese TITLE DHR

PRINT NAME PAULA SAVARESE DATE 1/21/05

SH 900.1 (12-03)

Stephen Farrell
Stephen FARRELL

Title: Director
DATE: 1/21/05

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of TB Control Manhattan Chest Clinic	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 1309 Fulton Avenue 1st Fl	AVERAGE NUMBER OF EMPLOYEES 17
CITY, STATE, ZIP CODE Bronx NY 10463	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 24,000
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Wanda Osborne TITLE PPA

PRINT NAME Wanda Osborne DATE 12/29/04

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYEMENT INFORMATION
ESTABLISHMENT NAME Environmental Health Jamaica Pest Control	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 120-34 Queens Blvd Rm 426	AVERAGE NUMBER OF EMPLOYEES 30
CITY, STATE, ZIP CODE Kew Gardens, N.Y.C. N.Y. 11415	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 41,092
INDUSTRY DESCRIPTION (e.g., village fire department) New York City Dept. of Health	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561710 488999 923120	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	40 (Col. K.)	INJURIES	1 (Col. 1)
DAYS AWAY FROM WORK	1 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Deborah Bacon TITLE P.A.A.I

PRINT NAME Deborah Bacon DATE 3/2/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Environmental Health PEST CONTROL SERVICES - Astoria	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 12-26 31st AVE. Rm 330	AVERAGE NUMBER OF EMPLOYEES 14
CITY, STATE, ZIP CODE ASTORIA, NY 11106	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC DEPT OF HEALTH & MENTAL HYGIENE	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 24,500
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561710, 561110, 488490	

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

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

6. CERTIFICATION

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

SIGNATURE _____ TITLE ASSISTANT DIRECTOR

PRINT NAME HAROLD RHODES DATE 2-22-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Veterinary & Pest Control Services North Brooklyn Pest Control Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 130 Nostrand Ave	AVERAGE NUMBER OF EMPLOYEES 39
CITY, STATE, ZIP CODE Brooklyn NY 11434	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 70,980
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept. of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561710 488999 923120	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	8 (Col. K.)	INJURIES	2 (Col. 1)
DAYS AWAY FROM WORK	2 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Vincent R. Coulbourne TITLE Regional Director

PRINT NAME VINCENT R COULBOURNE DATE 1/4/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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

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

1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of TB Control Washington Heights Chest Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 600 W. 168 Street 3rd floor	AVERAGE NUMBER OF EMPLOYEES 9
CITY, STATE, ZIP CODE New York New York 10032	
INDUSTRY DESCRIPTION (e.g., village fire department) NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 15,435
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Elsie Zayas TITLE Cont Adm

PRINT NAME Elsie Zayas DATE 12/28/04

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Maternal, Infant & Reproductive Health - Newborn Project	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 2238 5th Ave 2nd fl Rm 241	AVERAGE NUMBER OF EMPLOYEES 6
CITY, STATE, ZIP CODE New York, NY 10037	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 10,500
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 624190	

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

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

6. CERTIFICATION

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

SIGNATURE Raymond Stephens TITLE Proj. Director

PRINT NAME H. STEPHENS, JR DATE 1/19/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME Environmental Health Service Health Academy	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 160 W 100th St, Rm 109	AVERAGE NUMBER OF EMPLOYEES 9
CITY, STATE, ZIP CODE New York, NY 10025	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 15,300
INDUSTRY DESCRIPTION (e.g., village fire department) Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 611699	

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

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

6. CERTIFICATION

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

SIGNATURE Dorene Terry-Bess TITLE Asst. Director

PRINT NAME Dorene Terry-Bess DATE 1/21/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Human Resources - EAP Program	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 346 Broadway Rm 708	AVERAGE NUMBER OF EMPLOYEES 5
CITY, STATE, ZIP CODE New York NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 8110
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561310	

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

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

6. CERTIFICATION

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

SIGNATURE IRamlakhan **TITLE** Health & Safety Compliance Inspector

PRINT NAME INGRID RAMLAKHAN **DATE** 1/31/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Bureau of Operations, Bedford District HC	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 485 Throop Avenue, 1st & Basement	AVERAGE NUMBER OF EMPLOYEES: 7
CITY, STATE, ZIP CODE: Brooklyn, N.Y. 11221	
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept. of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 7,740
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 561720	

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

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

6. CERTIFICATION

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

SIGNATURE Burt Roberts TITLE MSW

PRINT NAME Burt Roberts DATE 02/15/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Veterinary Public Health Services	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 40 Worth Street, Room 1522 and 1523	AVERAGE NUMBER OF EMPLOYEES 21
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept. of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 34,860
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 9 2 3 1 2 0 and 5 4 1 9 4 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 (Col. G.)	AWAY FROM WORK	0 (Col. K.)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Camilo Zamora TITLE Associate Staff Analyst

PRINT NAME Camilo Zamora DATE 2/17/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME (Mental Hygiene) NYC Early Intervention Program - Central Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 93 Worth St, RM 303, 910 & 915	AVERAGE NUMBER OF EMPLOYEES 31
CITY, STATE, ZIP CODE NYC. NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 56,473
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC DOHMH	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 624110	

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

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

6. CERTIFICATION

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

SIGNATURE Gary Blaustein TITLE EIP-Office Svc Coordinator

PRINT NAME Gary Blaustein DATE 2/14/05

SH 900.1 (12-03)

2004

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Bureau of Communicable Disease	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 125 Worth Street	AVERAGE NUMBER OF EMPLOYEES: 67
CITY, STATE, ZIP CODE: New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept. of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 122,409
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 621111 621399	

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

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

6. CERTIFICATION

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

SIGNATURE _____ TITLE Admin Director

PRINT NAME Vera Bathen DATE 1-19-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: HCAI, Oral Health, Programs and Policy - Central Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 299 Broadway, Suite 500	AVERAGE NUMBER OF EMPLOYEES: 28
CITY, STATE, ZIP CODE: New York, NY 10007	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 48,458
INDUSTRY DESCRIPTION (e.g.. village fire department): Department of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 621210 621399	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	27 (Col. K.)	INJURIES	1 (Col. 1)
DAYS AWAY FROM WORK	2 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	2 (Col. 3)
OTHER RECORD-ABLE CASES	1 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE: James Wolin TITLE: Director, Operations Management and Budget

PRINT NAME: JAMES WOLIN DATE: 1/14/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: ORAL HEALTH Programs & Policy, Region (IV)	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 3525 Nostrand Avenue, 1st Floor	AVERAGE NUMBER OF EMPLOYEES: 32
CITY, STATE, ZIP CODE: Brooklyn, NY. 11229	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 45,425
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 621210 923120	

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

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

6. CERTIFICATION

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

SIGNATURE: Sheldon Lisogorsky TITLE: Regional Administration Dir.

PRINT NAME: Sheldon Lisogorsky DATE: 2-1-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: ORAL HEALTH PROGRAMS & POLICY- REGION 1	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 600 W. 168 ST - DENTAL CLINIC	AVERAGE NUMBER OF EMPLOYEES: 3
CITY, STATE, ZIP CODE: NEW YORK, NY 10032	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 4250
INDUSTRY DESCRIPTION (e.g., village fire department): NYC DOHMH	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 621210 923120	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	92 (Col. K.)	INJURIES	1 (Col.1)
DAYS AWAY FROM WORK	1 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col.2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col.3)
OTHER RECORDABLE CASES	0 (Col. J.)			POISONINGS	0 (Col.4)
				HEARING LOSS	0 (Col.5)
				ALL OTHER ILLNESSES	0 (Col.6)

6. CERTIFICATION

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

SIGNATURE: Mark Lewis TITLE: Regional Director

PRINT NAME: MARK LEWIS DATE: 1/5/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Operations, Homecrest District Health Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 1601 Avenue 'S'	AVERAGE NUMBER OF EMPLOYEES 4
CITY, STATE, ZIP CODE Brooklyn, New York 11229	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 7535
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561720 923120	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	0 (Col. K.)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	8 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Burt Roberts TITLE Health Service Manager

PRINT NAME Burt Roberts DATE 02/23/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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

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

1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Division of Administration DOHMH Call Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 40 North Street, Room 1610	AVERAGE NUMBER OF EMPLOYEES 50
CITY, STATE, ZIP CODE NY NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 69,160
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept. of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120	

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

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

6. CERTIFICATION

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

SIGNATURE Pamela L. Harmon TITLE Director

PRINT NAME Pamela L. Harmon DATE 2-24-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Immunization-Corona Health Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 34-33 Junction Boulevard, 1st Floor	AVERAGE NUMBER OF EMPLOYEES 7
CITY, STATE, ZIP CODE Corona, NY 11372	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 12,250
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Robert Young **TITLE** Staff Analyst

PRINT NAME Robert Young **DATE** 1-31-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Immunization-Kew Gardens Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 120-34 Queens Boulevard, 3rd Floor	AVERAGE NUMBER OF EMPLOYEES 7
CITY, STATE, ZIP CODE Kew Gardens, NY 10415	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 12,250
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE _____ **TITLE** Staff Analyst

PRINT NAME Robert Young **DATE** 1-31-05

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Immunization-Central Harlem Clinic	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 1727 Amsterdam Avenue, 3rd Floor	AVERAGE NUMBER OF EMPLOYEES 32
CITY, STATE, ZIP CODE New York, NY 10031	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 56,000
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	**AWAY FROM WORK**	7 (Col. K.)	**INJURIES**	0 (Col. 1)
DAYS AWAY FROM WORK	2 (Col. H.)	**JOB TRANSFER OR RESTRICTION**	0 (Col. L.)	**SKIN DISORDERS**	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			**RESPIRATORY CONDITIONS**	2 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			**POISONINGS**	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE _____ **TITLE** Staff Analyst

PRINT NAME Robert Young **DATE** 1-31-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Immunization-Chelsea Health Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 303 9th Avenue, 1st Floor	AVERAGE NUMBER OF EMPLOYEES 7
CITY, STATE, ZIP CODE New York, NY 10001	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 12,250
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	**AWAY FROM WORK**	180 (Col. K.)	**INJURIES**	1 (Col. 1)
DAYS AWAY FROM WORK	1 (Col. H.)	**JOB TRANSFER OR RESTRICTION**	0 (Col. L.)	**SKIN DISORDERS**	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			**RESPIRATORY CONDITIONS**	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			**POISONINGS**	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE _____ **TITLE** Staff Analyst

PRINT NAME Robert Young **DATE** 1-31-05

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Immunization-Public Health Lab / Vaccines for Children	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 455 1st Avenue, Room 154	AVERAGE NUMBER OF EMPLOYEES 14
CITY, STATE, ZIP CODE New York, NY 10016	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 24,745
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	**AWAY FROM WORK**	57 (Col. K.)	**INJURIES**	2 (Col. 1)
DAYS AWAY FROM WORK	2 (Col. H.)			**SKIN DISORDERS**	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)	**JOB TRANSFER OR RESTRICTION**	0 (Col. L.)	**RESPIRATORY CONDITIONS**	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			**POISONINGS**	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE _____ **TITLE** Staff Analyst

PRINT NAME Robert Young **DATE** 1-31-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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Public Employee Safety and Health Bureau
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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Immunization-Tremont Health Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 1826 Arthur Avenue, 1st Floor	AVERAGE NUMBER OF EMPLOYEES 7
CITY, STATE, ZIP CODE Bronx, NY 10457	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 12,250.
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE _____ **TITLE** Staff Analyst

PRINT NAME Robert Young **DATE** 1-31-05

STATE OF NEW YORK
DEPARTMENT OF LABOR

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Immunization-Central Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 2 Lafayette Street, 19th Floor	AVERAGE NUMBER OF EMPLOYEES 71
CITY, STATE, ZIP CODE New York, NY 10007	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 124,250
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	**AWAY FROM WORK**	112 (Col. K.)	**INJURIES**	3 (Col. 1)
DAYS AWAY FROM WORK	4 (Col. H.)	**JOB TRANSFER OR RESTRICTION**	0 (Col. L.)	**SKIN DISORDERS**	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			**RESPIRATORY CONDITIONS**	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			**POISONINGS**	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	1 (Col. 6)

6. CERTIFICATION

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

SIGNATURE _____ **TITLE** Staff Analyst

PRINT NAME Robert Young **DATE** 1-31-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Maternal, Infant & Reproductive Health - NewBorn Project	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 485 THROOP AVE, 1ST FLOOR	AVERAGE NUMBER OF EMPLOYEES 6
CITY, STATE, ZIP CODE Brooklyn, NY 11221	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 10,500
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 624190	

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

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

6. CERTIFICATION

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

SIGNATURE Raymond Stephney Jr. TITLE Proj. Director

PRINT NAME H. STEPHNEY, JR DATE 1/19/05

SH 900.1 (12-03)

STATE OF NEW YORK
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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Operations, Homecrest District Health Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 1601 Avenue 'S'	AVERAGE NUMBER OF EMPLOYEES 4
CITY, STATE, ZIP CODE Brooklyn, New York 11229	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 7535
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561720 923120	

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

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

6. CERTIFICATION

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

SIGNATURE Burt Roberts TITLE Health Service Manager

PRINT NAME Burt Roberts DATE 02/23/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Operations - Graphics	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 125 Worth St., Rm. 1027	AVERAGE NUMBER OF EMPLOYEES: 4
CITY, STATE, ZIP CODE: New York, NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 6930
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept. of Health + Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 323115	

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

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

6. CERTIFICATION

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

SIGNATURE: Christine Abril TITLE: PAA

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

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Operations - Reproduction Unit	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 125 Worth St., Basement	AVERAGE NUMBER OF EMPLOYEES: 13
CITY, STATE, ZIP CODE: New York, NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 23,850
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept. of Health + Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 323117 323119	

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

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

6. CERTIFICATION

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

SIGNATURE Christine Abril TITLE PAA

PRINT NAME Christine Abril DATE 2/1/05

SH 900.1 (12-03)

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Bureau of Environmental Disease Prevention	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 253 Broadway, 11th floor, 12th floor, Room 603	AVERAGE NUMBER OF EMPLOYEES: 138
CITY, STATE, ZIP CODE: New York, NY 10007	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 242,060
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Department of Health and Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 541620 541990	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	28 (Col. K.)	INJURIES	5 (Col. 1)
DAYS AWAY FROM WORK	4 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	1 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE _____ TITLE Asst Commissioner

PRINT NAME Jessica Leighton DATE 2/2/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of TB Control. BROWNSVILLE CHEST CENTER	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 259 BRISTOL STREET 3rd floor	AVERAGE NUMBER OF EMPLOYEES 8
CITY, STATE, ZIP CODE BROOKLYN NY 11212	
INDUSTRY DESCRIPTION (e.g., village fire department) NYC Dept. of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 11,760
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Gillespie for P.Duah TITLE Center Administrative Mgr.

PRINT NAME Gillespie for P.Duah DATE 1-18-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Bureau of Operations Williamsburg District Health Center.	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 151 Maujer Street	AVERAGE NUMBER OF EMPLOYEES: 4
CITY, STATE, ZIP CODE: Brooklyn, NY 11206	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 9,160
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept of Health & Mental Hygiene.	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 561720	

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

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

6. CERTIFICATION

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

SIGNATURE: Irene Burks TITLE: CA IV

PRINT NAME: Irene Burks DATE: 1/14/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Online Editing Bureau of Communications	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 125 Worth St, Rm 329	AVERAGE NUMBER OF EMPLOYEES: 6
CITY, STATE, ZIP CODE: New York, N.Y. 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 9,380
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Department of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 516110	

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

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

6. CERTIFICATION

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

SIGNATURE [signature] TITLE PM6

PRINT NAME Alvin Mera DATE 1/26/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Communications Health Media & Marketing	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 Worth St, Rm 342	AVERAGE NUMBER OF EMPLOYEES 12
CITY, STATE, ZIP CODE New York N.Y 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 19,670
INDUSTRY DESCRIPTION (e.g., village fire department) NYC Department of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 519190	

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

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

6. CERTIFICATION

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

SIGNATURE _____ TITLE PHD

PRINT NAME OLIVIA MEKA DATE 1/26/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Communications/Community Relations	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 Worth Rm 1047	AVERAGE NUMBER OF EMPLOYEES 4
CITY, STATE, ZIP CODE New York N.Y. 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 9170
INDUSTRY DESCRIPTION (e.g., village fire department) NYC Department of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 541840	

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

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

6. CERTIFICATION

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

SIGNATURE _____ TITLE PHL

PRINT NAME OLIVIA MERA DATE 1/26/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Communications Press Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 Worth, Rm 329	AVERAGE NUMBER OF EMPLOYEES 9
CITY, STATE, ZIP CODE New York, N.Y. 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 13,300
INDUSTRY DESCRIPTION (e.g., village fire department) NYC Department of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 541820	

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

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

6. CERTIFICATION

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

SIGNATURE [signature] TITLE PHO

PRINT NAME OLIVIA MERA DATE 4/26/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Bureau of Communications/Cross Cultural / PMO office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 125 Worth, Rm 1047	AVERAGE NUMBER OF EMPLOYEES: 7
CITY, STATE, ZIP CODE: New York, N.Y 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 10,920
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Department of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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

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

6. CERTIFICATION

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

SIGNATURE _____ TITLE PMO

PRINT NAME OLIVIA MERA DATE 2/26/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Bureau of TB Control Education & Training Unit	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 253 Broadway, 7th Floor	AVERAGE NUMBER OF EMPLOYEES: 6
CITY, STATE, ZIP CODE: New York, N.Y 10007	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 9,010
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Valerie L. Gunn TITLE ASA

PRINT NAME Valerie Gunn DATE 12/31/04

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME VETERINARY AND PEST CONTROL SERVICES - CENTRAL OFFICE	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 WORTH STREET, ROOM 619	AVERAGE NUMBER OF EMPLOYEES 6
CITY, STATE, ZIP CODE NEW YORK, NY 10013	
INDUSTRY DESCRIPTION (e.g., village fire department) NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 11,885
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120	

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

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

6. CERTIFICATION

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

SIGNATURE Delia Payne TITLE Research Assistant

PRINT NAME Delia Payne DATE 1/11/2005

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Finance Administrative Tribunal,	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 66 John St, 11th Fl.	AVERAGE NUMBER OF EMPLOYEES 41
CITY, STATE, ZIP CODE NY NY 10038	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 71,750
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 541219 518210	

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

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

6. CERTIFICATION

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

SIGNATURE Charles Paul Miller TITLE Asst Dir of Ops

PRINT NAME CHARLES PAUL MILLER DATE 2-1-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Office of Chief Medical Examiner	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 451 Clarkson Avenue T Building, Room 302	AVERAGE NUMBER OF EMPLOYEES: 44
CITY, STATE, ZIP CODE: Brooklyn, NY, 11203	
INDUSTRY DESCRIPTION (e.g., village fire department): Department of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 67600
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 623990	

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

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

6. CERTIFICATION

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

SIGNATURE: Ros — TITLE: Dir. of Health and Safety

PRINT NAME: Rosiborod — DATE: 01.25.05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Office of chief Medical Examiner	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS PELHEM Parkway South and East CHESTER Road	AVERAGE NUMBER OF EMPLOYEES 34
CITY, STATE, ZIP CODE BRONX, NY, 10461	
INDUSTRY DESCRIPTION (e.g., village fire department) Department of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 49660
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 623990	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	94 (Col. K.)	INJURIES	4 (Col. 1)
DAYS AWAY FROM WORK	3 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	1 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Kos — TITLE Dir. of Health and Safety

PRINT NAME Kosiborod — DATE 01.25.05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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

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

1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Office of chief Medical Examiner	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 82-68, 164 street H Building	AVERAGE NUMBER OF EMPLOYEES 37
CITY, STATE, ZIP CODE Queens, NY, 11435	
INDUSTRY DESCRIPTION (e.g., village fire department) Department of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 65000
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 623990	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	180 (Col. K.)	INJURIES	1 (Col. 1)
DAYS AWAY FROM WORK	1 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Kos TITLE Dir. of Health and Safety

PRINT NAME Kosiborod DATE 01.25.05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME Office of Chief Medical Examiner	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 460-Brielle Avenue Seaview Mortuary	AVERAGE NUMBER OF EMPLOYEES 11
CITY, STATE, ZIP CODE Staten Island, NY, 10314	
INDUSTRY DESCRIPTION (e.g., village fire department) Department of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 10920
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 623990	

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

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

6. CERTIFICATION

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

SIGNATURE Kos TITLE Dir. of Health and Safety

PRINT NAME Kosiborod DATE 01.25.05

SH 900.1 (12-03)

Fax: Feb 2 2005 11:47 P.04

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME N.Y.C. DEPT OF HEALTH BUREAU OF LABORATORIES	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 455 1ST AVENUE Floors B through 12	AVERAGE NUMBER OF EMPLOYEES 203
CITY, STATE, ZIP CODE N.Y.C., N.Y. 10016	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 360,070
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 621511, 621399, 541380, 541710	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	190 (Col. K.)	INJURIES	7 (Col. 1)
DAYS AWAY FROM WORK	7 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	1 (Col. 3)
OTHER RECORD-ABLE CASES	4 (Col. J.)			POISONINGS	1 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	2 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Diana Wysocki TITLE Comm. Coordinator

PRINT NAME DIANA WYSOCKI DATE 1-18-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME BUREAU OF SCHOOL HEALTH QUEENS SCHOOL HEALTH REGIONAL OFFICE	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 120-34 QUEENS BLVD	AVERAGE NUMBER OF EMPLOYEES 310
CITY, STATE, ZIP CODE KEW GARDENS NY 11415	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC DEPT. OF. HEALTH & MENTAL HYGIENE	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 432,700
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 624110, 621111, 621399, 923120	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	77 (Col. K.)	INJURIES	14 (Col. 1)
DAYS AWAY FROM WORK	10 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	4 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Richard Fox TITLE REGIONAL MANAGER

PRINT NAME RICHARD FOX DATE 1/19/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau Of Operations-Ft Greene Health Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 295 Flatbush Avenue Ext., Basement	AVERAGE NUMBER OF EMPLOYEES 6
CITY, STATE, ZIP CODE Brooklyn, NY 11201	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 10,584
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 561720	

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

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

6. CERTIFICATION

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

SIGNATURE Beverly McDonald TITLE Health Services Manager

PRINT NAME Beverly McDonald DATE 1/31/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Early InterventionProgram - Queens	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 59 - 17 Junction Blvd. 2nd floor	AVERAGE NUMBER OF EMPLOYEES 41
CITY, STATE, ZIP CODE Corona, NY 11368	
INDUSTRY DESCRIPTION (e.g., village fire department) New York City Dept. of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 71,750
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 624190	

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

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

6. CERTIFICATION

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

SIGNATURE John Parra TITLE Secretary

PRINT NAME John Parra DATE 03/29/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME ACCO's Office & Procurement	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 93 Worth St., Rm: 812 / 125 Worth St. Rm: 1002	AVERAGE NUMBER OF EMPLOYEES 50
CITY, STATE, ZIP CODE New York, NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 91000
INDUSTRY DESCRIPTION (e.g., village fire department) N.Y.C. Dept. of Health + Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561110	

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

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

6. CERTIFICATION

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

SIGNATURE Barbara J. Madison TITLE PMO

PRINT NAME Barbara J. Madison DATE 01/03/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of STD Control-Richmond HC	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 51 Stuyvesant Place, 1st Floor	AVERAGE NUMBER OF EMPLOYEES 2
CITY, STATE, ZIP CODE Staten Island, NY 10301	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 910
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Lucas Williams TITLE Clinic Manager

PRINT NAME Lucas B. Williams DATE 4/29/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Day Care-Family Day Care Bronx	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 1309 Fulton Avenue, 3rd Floor	AVERAGE NUMBER OF EMPLOYEES 43
CITY, STATE, ZIP CODE Bronx, NY 10456	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 76,368
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 624110	

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

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

6. CERTIFICATION

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

SIGNATURE Ramlakhan for D. Santiago **TITLE** Health & Safety Officer

PRINT NAME Ingrid Ramlakhan/Debbie Santiago **DATE** 5/9/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of STD Control-Bedford HC	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 485 Throop Avenue, 1st Floor	AVERAGE NUMBER OF EMPLOYEES 15
CITY, STATE, ZIP CODE Brooklyn, NY 11221	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 25,200
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Vincent Dufour TITLE Clinic Manager

PRINT NAME Vincent Dufour DATE 4/29/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Employee Law Unit	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 2 Lafayette Street, 22nd Floor	AVERAGE NUMBER OF EMPLOYEES 6
CITY, STATE, ZIP CODE New York, NY 10007	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 10,580
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 541110, 561110	

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

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

6. CERTIFICATION

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

SIGNATURE Rawlabhan for R Bryant **TITLE** HSCO

PRINT NAME Rena Bryant **DATE** 5/10/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
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Albany NY 12240

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME General Counsel for Health	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 Worth Street, Rooms 601-609	AVERAGE NUMBER OF EMPLOYEES 18
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 32,240
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 541110, 561110	

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

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

6. CERTIFICATION

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

SIGNATURE Ramlakhan for R. Bryant **TITLE** AISCO

PRINT NAME Rena Bryant **DATE** 5/10/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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

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

1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Food Safety and Community Sanitation	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 253 Broadway, 6th, 12th and 13th Floors	AVERAGE NUMBER OF EMPLOYEES 181
CITY, STATE, ZIP CODE New York, NY 10007	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 358,005
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 541990 541350	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	158 (Col. K.)	INJURIES	10 (Col. 1)
DAYS AWAY FROM WORK	11 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	1 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Michele Lignore-Diaz TITLE Associate Staff Analyst

PRINT NAME Michele Lignore-Diaz DATE 1/24/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: DOHMH Immunization Program	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 2 Lafayette ST.	AVERAGE NUMBER OF EMPLOYEES: 174
CITY, STATE, ZIP CODE: N.Y. NY. 10007	
INDUSTRY DESCRIPTION (e.g.,village fire department): Health Department	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 292,320
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS).	

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

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

6. CERTIFICATION

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

SIGNATURE: Robt Young TITLE: HSCO

PRINT NAME: Robert Young DATE: JAN 7, 2004

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: ACCO's Office

STREET ADDRESS: 93 Worth Street, Rm: 806

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

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

STANDARD INDUSTRIAL CLASSIFICATION (SIC), IF KNOWN.

2. EMPLOYMENT INFORMATION

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

AVERAGE NUMBER OF EMPLOYEES: 50

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 91000

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

3. NUMBER OF CASES

DEATHS	0	(Col. G)
DAYS AWAY FROM WORK	6	(Col. H)
JOB TRANSFER OR RESTRICTION	0	(Col. I)
OTHER RECORD-ABLE CASES	0	(Col. J:)

4. NUMBER OF DAYS

JOB TRANSFER OR RESTRICTION	0	(Col. K)
AWAY FROM WORK	6	(Col. L)

5. INJURIES AND ILLNESS TYPES

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

6. CERTIFICATION

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

SIGNATURE: Barbara J. Madison

TITLE: PMO

PRINT NAME: Barbara J. Madison

DATE: 06/02/04

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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

2004

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Bureau of HIV/AIDS	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 40 Worth St 15th Floor Rm 1513	AVERAGE NUMBER OF EMPLOYEES: 76
CITY, STATE, ZIP CODE: New York, N.Y. 10013	
INDUSTRY DESCRIPTION (e.g., village fire department): New York City Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 130,000
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120, 561110, 541720	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESS TYPES	
DEATHS	0 (Col. G)	JOB TRANSFER OR RESTRICTION	0 (Col. ~~I~~ J)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H)	AWAY FROM WORK	0 (Col. K)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORDABLE CASES	0 (Col. J)			POISONINGS	0 (Col. 4)
				ALL OTHER ILLNESSES	0 (Col. ~~5~~ 6)
				Hearing Loss	0 Col 5

6. CERTIFICATION

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

SIGNATURE Saundra P. Gilkes TITLE Health & Safety Officer, ASA

PRINT NAME SAUNDRA P. GILKES DATE 2/11/05

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Veterinary Services And Pest Control Bureau of Vector Control	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 2 Lafayette st. / 520 Kingsland Ave	AVERAGE NUMBER OF EMPLOYEES 18
CITY, STATE, ZIP CODE Ny, Bklyn, NY 10007, 11222	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 32,590
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120,561710	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	10 (Col. K.)	INJURIES	2 (Col. 1)
DAYS AWAY FROM WORK	2 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Robert L Champion TITLE APHS II

PRINT NAME Robert L Champion DATE 3/4/2005

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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(includes Community sites)

1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: ORAL HEALTH PROGRAMS & POLICY - Region II MANHATTAN REGIONAL OFFICE - E. Harlem DHC	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 158 E. 115 Street Rm 222	AVERAGE NUMBER OF EMPLOYEES: 25
CITY, STATE, ZIP CODE: New York, NY 10029	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 29,385
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 621210, 923120	

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

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

6. CERTIFICATION

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

SIGNATURE Toni D. Smith TITLE Regional Adm. Director

PRINT NAME TONI D. SMITH DATE 1/12/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau Of Tuberculosis Control - Central Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 225 BROADWAY, 22nd FLOOR	AVERAGE NUMBER OF EMPLOYEES 90
CITY, STATE, ZIP CODE NEW YORK, NY 10007	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 158,400
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Juanita Chinn TITLE OFFICE MANAGER

PRINT NAME JUANITA CHINN DATE 1-27-2005

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Human Resources - Central Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 WORTH ST Rm 930, 900-914	AVERAGE NUMBER OF EMPLOYEES 89
CITY, STATE, ZIP CODE New York NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 147,250
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 541612 561110	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	**AWAY FROM WORK**	20 (Col. K.)	**INJURIES**	2 (Col. 1)
DAYS AWAY FROM WORK	1 (Col. H.)	**JOB TRANSFER OR RESTRICTION**	14 (Col. L.)	**SKIN DISORDERS**	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	1 (Col. I.)			**RESPIRATORY CONDITIONS**	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			**POISONINGS**	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE IRamlakhan **TITLE** Health & Safety Compliance Inspector

PRINT NAME INGRID RAMLAKHAN **DATE** 1/31/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYEE INFORMATION
ESTABLISHMENT NAME Bureau of Operations Tremont Health Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 1826 Arthur Avenue - Executive Office Rm 134	AVERAGE NUMBER OF EMPLOYEES 1
CITY, STATE, ZIP CODE Bronx NY 10457	
INDUSTRY DESCRIPTION (e.g., village fire department) NYC Dept. of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 2,372
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 561720	

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

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

6. CERTIFICATION

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

SIGNATURE Valerie Bailey TITLE Health Services Manager

PRINT NAME Valerie Bailey DATE 1/20/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Office of chief Medical Examiner	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 520 First Avenue	AVERAGE NUMBER OF EMPLOYEES: 462
CITY, STATE, ZIP CODE: Manhattan, NY. 10016	
INDUSTRY DESCRIPTION (e.g., village fire department): Department of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 762424
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 492210, 621511, 623990, 923120	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	482 (Col. K.)	INJURIES	15 (Col. 1)
DAYS AWAY FROM WORK	13 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	2 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE: [signature] TITLE: Dir. of Health and Safety

PRINT NAME: Kosiborod DATE: 01.25.05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: BUREAU OF TB CONTROL - ADMINISTRATION	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 125 WORTH ST, RM. 216, 214.	AVERAGE NUMBER OF EMPLOYEES: 44
CITY, STATE, ZIP CODE: NY NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 78,000
INDUSTRY DESCRIPTION (e.g.. village fire department): DOHMH	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 561110 923120 541720	

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

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

6. CERTIFICATION

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

SIGNATURE Floyd Lawrence TITLE ASSOCIATE STAFF ANALYST

PRINT NAME FLOYD LAWRENCE DATE 12/31/04

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of TB Control - SRO outreach main office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 225 Broadway 22nd floor	AVERAGE NUMBER OF EMPLOYEES 22
CITY, STATE, ZIP CODE New York, NY 10007	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Dept of Health, Mental Hygiene.	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 37,856
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

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

6. CERTIFICATION

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

X SIGNATURE Shameer Pooja TITLE Homeless Services Coordinator

PRINT NAME Shameer Pooja DATE 1/12/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Maternal Infant & Reproductive Health - Bureau of Community Education Services	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 25 Chapel St, Suite 1006	AVERAGE NUMBER OF EMPLOYEES 9
CITY, STATE, ZIP CODE Brooklyn, NY 11201	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 15,600
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene.	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 624190	

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

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

6. CERTIFICATION

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

SIGNATURE Yvonne Sinclair TITLE Director CES

PRINT NAME Yvonne Sinclair DATE 1/19/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Operations Astoria Health Center,	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 12-26 31st Avenue, 1st Fl & Basement	AVERAGE NUMBER OF EMPLOYEES 4
CITY, STATE, ZIP CODE Astoria, NY 11106	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 6,700
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 561720	

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

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

6. CERTIFICATION

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

SIGNATURE Kevin McGrath TITLE Health Services Manager

PRINT NAME Kevin McGrath DATE 1/28/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Operations: Corona Health Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 34-33 Junction Boulevard, Basement	AVERAGE NUMBER OF EMPLOYEES 6
CITY, STATE, ZIP CODE Jackson Heights, NY 11372	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 9,231
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 561720	

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

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

6. CERTIFICATION

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

SIGNATURE Kevin McGrath TITLE Health Services Manager

PRINT NAME Kevin McGrath DATE 1/28/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Operations Lower Manhattan Health Center (Chelsea)	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 303 Ninth Avenue	AVERAGE NUMBER OF EMPLOYEES 5
CITY, STATE, ZIP CODE New York, NY 10001	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 8,839
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 561720	

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

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

6. CERTIFICATION

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

SIGNATURE Kevin McGrath TITLE Health Services Manager

PRINT NAME Kevin McGrath DATE 1/28/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Bureau of Operations JAMAICA HEALTH CENTER	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 90-37 PARSONS BOULEVARD, 2nd FL E/B	AVERAGE NUMBER OF EMPLOYEES: 5
CITY, STATE, ZIP CODE: JAMAICA, N.Y. 11432	
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 8,120
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120, 561720	

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

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

6. CERTIFICATION

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

SIGNATURE: Kevin McGrath TITLE: HEALTH SERVICES MANAGER

PRINT NAME: KEVIN McGRATH DATE: 1/28/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of internal accounting	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 Worth St, 916, 917, 920 & 923	AVERAGE NUMBER OF EMPLOYEES 32
CITY, STATE, ZIP CODE N.Y. N.Y. 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 52,539
INDUSTRY DESCRIPTION (e.g.. village fire department) N.Y.C. Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 541990	

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

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

6. CERTIFICATION

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

SIGNATURE La Dawn Rasheed TITLE associate accountant

PRINT NAME LA DAWN RASHEED DATE 3/9/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Bureau of STD Control (Crown Heights)	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 1218 Prospect Place 2FL	AVERAGE NUMBER OF EMPLOYEES: 22
CITY, STATE, ZIP CODE: Brooklyn NY 11213	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 37,730
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept of Health & Mental Hyg.	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120, 621399	

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

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

6. CERTIFICATION

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

SIGNATURE: Vincent Dufour TITLE: Clinic Manager

PRINT NAME: Vincent Dufour DATE: 1-31-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Immunization – HOMECREST H.C.	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 1601 AVENUE S, 1ST FLOOR	AVERAGE NUMBER OF EMPLOYEES 6
CITY, STATE, ZIP CODE BROOKLYN NY 11229	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 10,290
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE _____ **TITLE** Staff Analyst

PRINT NAME Robert Young **DATE** 1-31-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: ORAL HEALTH PROGRAMS & POLICY LOWER MANHATTAN HEALTH CENTER	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 303 Ninth Avenue, 1ST FL.	AVERAGE NUMBER OF EMPLOYEES: 7
CITY, STATE, ZIP CODE: New York, NY 10029	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 11,334
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 621210, 923120	

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

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

6. CERTIFICATION

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

SIGNATURE Toni J. Smith TITLE Regional Adm. Director.

PRINT NAME TONI D. SMITH DATE 1/20/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME HPDP Bronx District Public Health Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 1826 Arthur Avenue, 1st Floor.	AVERAGE NUMBER OF EMPLOYEES 20
CITY, STATE, ZIP CODE Bronx, N.Y.C. N.Y. 10457	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 36,540
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Health Department	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621111	

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

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

6. CERTIFICATION

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

SIGNATURE _____ TITLE Administrator

PRINT NAME Carlos R. Fortuno DATE January 6, 2005.

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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State Office Campus
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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
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2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of TB Control Richmond Chest Clinic	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 51 Stuyvesant Place 4th fl	AVERAGE NUMBER OF EMPLOYEES 18
CITY, STATE, ZIP CODE Staten Island, NY 10301	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 15,000
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Wanda Osborne TITLE PAA

PRINT NAME Wanda Osborne DATE 12/29/04

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME Bureau of operations Central Harlem H.C.	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 2238 FIFTH AVENUE	AVERAGE NUMBER OF EMPLOYEES 3
CITY, STATE, ZIP CODE New York N.Y. 10035	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 5,500
INDUSTRY DESCRIPTION (e.g., village fire department) N.Y.C. Dept. of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 561720	

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

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

6. CERTIFICATION

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

SIGNATURE Norbert Ataandl TITLE Health Services Mgr

PRINT NAME NORBERT ATAANDE DATE 1/28/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

2004

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

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

1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Operations East Harlem Health Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 158 East 115 Street	AVERAGE NUMBER OF EMPLOYEES 7
CITY, STATE, ZIP CODE New York N.Y. 10029	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 12,900
INDUSTRY DESCRIPTION (e.g., village fire department) N.Y.C. Dept. of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 561720	

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

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

6. CERTIFICATION

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

SIGNATURE Norbert Ataanole TITLE Health Services Mgr

PRINT NAME NORBERT ATAANOE DATE 1/25/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Division of Financial + Strategic Management - Administrative Offices	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 125 Worth St, Rm 620	AVERAGE NUMBER OF EMPLOYEES: 6
CITY, STATE, ZIP CODE: NY, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept. of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 11,200
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 541219	

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

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

6. CERTIFICATION

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

SIGNATURE: Jennifer Mendel TITLE: PMO

PRINT NAME: Jennifer Mendel DATE: 1/24/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Division of Epidemiology Bureau of Informatic Data Services	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 346 Broadway, Rooms 707A+B, 832	AVERAGE NUMBER OF EMPLOYEES: 29
CITY, STATE, ZIP CODE: New York, NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 43,995
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 621399 518210	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	215 (Col. K.)	INJURIES	1 (Col. 1)
DAYS AWAY FROM WORK	1 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE Laura Pelzer TITLE PAA 1

PRINT NAME Laura Pelzer DATE 1/18/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME ORAL HEALTH Programs & Policy Fort Greene Health Center.	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 295 Flatbush Ave, Ext 1st Floor	AVERAGE NUMBER OF EMPLOYEES 4
CITY, STATE, ZIP CODE Brooklyn, N.Y. 11201	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 6175
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 621210 923120	

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

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

6. CERTIFICATION

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

SIGNATURE Sheldon Lisagor TITLE Regional Administrative Dir

PRINT NAME Sheldon Lisagor DATE 2/1/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
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2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME EARLY INTERVENTION PROGRAM, Manhattan Regional Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 42 BROADWAY, SUITE 1027	AVERAGE NUMBER OF EMPLOYEES 31
CITY, STATE, ZIP CODE NEW YORK, NEW YORK 10004	
INDUSTRY DESCRIPTION (e.g., village fire department) NYC DOHMH	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 54,250
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 624190 , 923120	

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

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

6. CERTIFICATION

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

SIGNATURE Anthony Romain TITLE Coordinating Manager

PRINT NAME ANTHONY ROMAIN DATE 03/10/2005

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
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2004

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: Bronx Pest Control Office
STREET ADDRESS: 1826 Arthur Ave 1st Fl & B.
CITY, STATE, ZIP CODE: Bronx N.Y. 10457
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept of Health & Mental Hygiene
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 561710 - 561110 - 488490

2. EMPLOYENT INFORMATION

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

AVERAGE NUMBER OF EMPLOYEES: 56 (8@ 8HRS 48@ 7HRS)

TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 97,755

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

3. NUMBER OF CASES

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

4. NUMBER OF DAYS

AWAY FROM WORK	7	(Col. K.)
JOB TRANSFER OR RESTRICTION	0	(Col. L.)

5. INJURIES AND ILLNESSES TYPES

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

6. CERTIFICATION

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

SIGNATURE: Mary Freeman
PRINT NAME: MARY FREEMAN
TITLE: Regional Director
DATE: 3/11/05

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME EARLY INTERVENTION PROGRAM/QUALITY ASSURANCE	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 49-51 CHAMBERS STREET - ROOM 1033	AVERAGE NUMBER OF EMPLOYEES 20
CITY, STATE, ZIP CODE NEW YORK, NEW YORK 10007	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 34,300
INDUSTRY DESCRIPTION (e.g., village fire department) NYC DEPT OF HEALTH & MENTAL HYGIENE	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120, 624190	

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

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

6. CERTIFICATION

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

SIGNATURE Barbara Rooney TITLE Office Manager

PRINT NAME Barbara Rooney DATE 3/11/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

"2004"

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: ORAL HEALTH PROGRAMS & POLICY FOR NEW YORK CITY	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: CORONA HEALTH CENTER - DENTAL CLINIC 34-33 JUNCTION BLVD.	AVERAGE NUMBER OF EMPLOYEES: 15
CITY, STATE, ZIP CODE: QUEENS, NEW YORK, N.Y. - 11372	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 25,686
INDUSTRY DESCRIPTION (e.g.. village fire department): NEW YORK CITY DOHMH	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 621210	

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

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

6. CERTIFICATION

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

SIGNATURE: Stephen R. Kuman TITLE: REGIONAL ADMINISTRATIVE DIRECTOR

PRINT NAME: STEPHENS R. KUMAR DATE: 1/21/2005

SH 900.1 (12-03)

2004

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME Bureau of Operations Washington Heights Health Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 600 W 168th St. Rm 401, E, B - Executive Office	AVERAGE NUMBER OF EMPLOYEES 4
CITY, STATE, ZIP CODE New York, NY 10032	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 6,641
INDUSTRY DESCRIPTION (e.g., village fire department) NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 561720	

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

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

6. CERTIFICATION

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

SIGNATURE Valerie Barley TITLE Health Services Manager

PRINT NAME Valerie Barley DATE 1/20/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME BUREAU OF TUBERCULOSIS CONTROL, CENTRAL OFFICE	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 225 BROADWAY, 22nd FLOOR	AVERAGE NUMBER OF EMPLOYEES 90
CITY, STATE, ZIP CODE NEW YORK, NY 10007	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 158,400
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 561110 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Juanita Chinn TITLE OFFICE MANAGER

PRINT NAME JUANITA CHINN DATE 1-27-2005

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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Public Employee Safety and Health Bureau
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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: HIV/AIDS Services (JJAPP) Juvenile Justice AIDS Prevention Program	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 1826 Arthur Ave 4fl	AVERAGE NUMBER OF EMPLOYEES: 6
CITY, STATE, ZIP CODE: Bx NY 10457	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 9940
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept. of Health, Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 624110 923120	

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

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

6. CERTIFICATION

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

SIGNATURE: Shawnie Franklin TITLE: Assist Director

PRINT NAME: Shawnie Franklin DATE: 1/24/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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Public Employee Safety and Health Bureau
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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME NYC - DOHMH, Bureau of Maternal, Infant & Reproductive Health	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 164-19 Hillside Avenue, 1st Floor	AVERAGE NUMBER OF EMPLOYEES 11
CITY, STATE, ZIP CODE Jamaica, NY 11432	
INDUSTRY DESCRIPTION (e.g.. village fire department) Health Dept	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 18,585
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 624190	

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

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

6. CERTIFICATION

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

SIGNATURE Joy Palmer TITLE Program Coordinator

PRINT NAME Joy Palmer DATE 1/20/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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 Division of Epidemiology Central Admin, Bu of Epidemiology Services	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 worth Street Rm 201, 202, 315	AVERAGE NUMBER OF EMPLOYEES 50
CITY, STATE, ZIP CODE New York NY, 10013 (NY)	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 87500
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health+Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561110 923120 541720	

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

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

6. CERTIFICATION

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

SIGNATURE Donald Johnson TITLE Principal Admin Assoc.

PRINT NAME Donald Johnson DATE 1/24/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME (PPQD- Administration) Policy, Planning, Quality & Development-Dept. of Health/Hygiene	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 Worth Street, 6th Floor Room 627	AVERAGE NUMBER OF EMPLOYEES 8
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) Municipal Health Department	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 14, 000
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 56 1110 923120	

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

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

6. CERTIFICATION

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

SIGNATURE [signature] TITLE Assistant Commissioner

PRINT NAME Dan Lehman DATE Jan. 6, 05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

2004.

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME NYC DOHMH PPQD/ Policy + PLANNING	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 Worth Street, Rm 624	AVERAGE NUMBER OF EMPLOYEES 17
CITY, STATE, ZIP CODE New York, NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 29,800
INDUSTRY DESCRIPTION (e.g.. village fire department) Health Department	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561110 923120	

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

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

6. CERTIFICATION

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

SIGNATURE Dodsey Cyrus TITLE PAA

PRINT NAME DODSEY CYRUS DATE 1/5/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME NYC DOHMH/FSM/Management Information Services	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 125 Worth Street Room 1051, 10th Floor	AVERAGE NUMBER OF EMPLOYEES 56
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) Application Development/Project Management	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 98,500
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561110 541513	

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

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

6. CERTIFICATION

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

SIGNATURE Tamira Collins TITLE Clerical Acs. II

PRINT NAME Tamira Collins DATE 1/24/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME NYC DOHMH/FSM/Management Information Services	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 40 Worth Street Room 1539, 15th Floor	AVERAGE NUMBER OF EMPLOYEES 27
CITY, STATE, ZIP CODE New York, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department) Application Development/Project Management	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 46,500
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 561110 541513	

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

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

6. CERTIFICATION

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

SIGNATURE Tamika Collins TITLE Clerical Ass II

PRINT NAME Tamika Collins DATE 1/24/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Operations-Customer Svc./Telecommunication	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 125 Worth St. Rm. 1003 - 1020	AVERAGE NUMBER OF EMPLOYEES: 19
CITY, STATE, ZIP CODE: New York, NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 33,850
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept. of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 561990 517910	

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

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

6. CERTIFICATION

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

SIGNATURE: Christine Abril TITLE: PAA

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

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Operations/Administration/Contracts	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 125 Worth St., Rm. 1012 + 1020	AVERAGE NUMBER OF EMPLOYEES: 15
CITY, STATE, ZIP CODE: New York, NY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 26,680
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Dept. of Health + Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120 561990	

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

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

6. CERTIFICATION

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

SIGNATURE: Christine Abril TITLE: PAA

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

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
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Albany NY 12240

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME . EARLY INTERVENTION, BROOKLYN OFFICE	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 16 COURT STREET, 2ND AND 6TH FLOOR	AVERAGE NUMBER OF EMPLOYEES 66
CITY, STATE, ZIP CODE BROOKLYN, NY 11241	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 110646
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 624190	

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

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

6. CERTIFICATION

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

SIGNATURE [signature] TITLE COORDINATING MANAGER

PRINT NAME SIM PETERS DATE 1/27/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: HEALTH Promotion & Disease Prevention - Administrative office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 125 Worth Street, Rm 348	AVERAGE NUMBER OF EMPLOYEES: 18
CITY, STATE, ZIP CODE: NY, NY 10013	
INDUSTRY DESCRIPTION (e.g.. village fire department): NYC Department of Health mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 55,000
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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

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

6. CERTIFICATION

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

SIGNATURE: [signature] TITLE: Information Technology Intern

PRINT NAME: James Allen DATE: 1/5/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of Maternal Infant Reproductive Health & Healthy Start	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 485 THROOP AVENUE, 3rd floor	AVERAGE NUMBER OF EMPLOYEES 7
CITY, STATE, ZIP CODE BROOKLYN, NY 11221	
INDUSTRY DESCRIPTION (e.g., village fire department) NYC Dept. of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 12,740
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 624190	

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

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

6. CERTIFICATION

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

SIGNATURE Lorna M. J. Fairweather TITLE Project Director

PRINT NAME LORNA M. J. FAIRWEATHER DATE 1/21/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME Bureau of Maternal Infant Reproductive health - Central Office.	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS 2 LAFAYETTE Street 18th Floor	AVERAGE NUMBER OF EMPLOYEES 21
CITY, STATE, ZIP CODE New York NY 10007	
INDUSTRY DESCRIPTION (e.g., village fire department) NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 38,370
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS). 923120 624190	

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

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

6. CERTIFICATION

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

SIGNATURE JoAnna Quinn TITLE Office Manager

PRINT NAME JOANNA QUINN DATE 1-24-05

SH-900.1 (2-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of TB Control Queens Network Field Office	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 59-17 Junction Blvd, Room 1400	AVERAGE NUMBER OF EMPLOYEES 30
CITY, STATE, ZIP CODE Queens, NY 11368	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 52,500
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 621399 923120	

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

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

6. CERTIFICATION

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

SIGNATURE _____ TITLE CSM

PRINT NAME Crystal S. Mann DATE 1/25/05

SH 900.1 (12-03)

1/28/05
duplicate

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

2004

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"2004" 1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of TB Control Far Rockaway Chest Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 67-10 Rockaway Beach Blvd.	AVERAGE NUMBER OF EMPLOYEES 8
CITY, STATE, ZIP CODE Far Rockaway, NY 11692	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept. Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 2800
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 621399 923120	

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

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

6. CERTIFICATION

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

SIGNATURE [signature] TITLE Admin. Mgr.

PRINT NAME Luz Santana DATE 1/19/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME: Division of Financial & Strategic Management	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: Office of Grants Administration 125 Worth Street Room 623	AVERAGE NUMBER OF EMPLOYEES: 6
CITY, STATE, ZIP CODE: New York, NY 10013	
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Department of Health and Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 10920
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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

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

6. CERTIFICATION

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

SIGNATURE: Judith Gaskin TITLE: Prin Admin Assoc

PRINT NAME: JUDITH GASKIN DATE: 1/18/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: NYC DOHMH Distribution Center	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 520 Kingsland Avenue	AVERAGE NUMBER OF EMPLOYEES: 13
CITY, STATE, ZIP CODE: Brooklyn, N.Y. 11222	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 21735
INDUSTRY DESCRIPTION (e.g.. village fire department): Department of Health and Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): Adm of PH Services / Warehouse 493110	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	0 (Col. K.)	INJURIES	0 (Col. 1)
DAYS AWAY FROM WORK	0 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	8 (Col. 6)

6. CERTIFICATION

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

SIGNATURE [signature] TITLE Director

PRINT NAME Thomas Andrews DATE 1/27/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: DISEASE CONTROL ADMIN'S OFFICE	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 125 WORTH STREET, Room 326	AVERAGE NUMBER OF EMPLOYEES: 13
CITY, STATE, ZIP CODE: NEW YORK CITY 10013	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 22,230
INDUSTRY DESCRIPTION (e.g., village fire department): N.Y.C. DEPT. OF HEALTH ENTAL HYGIENE	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 923120	

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

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

6. CERTIFICATION

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

SIGNATURE: [signature] TITLE: STAFF ANALYST

PRINT NAME: [illegible] DATE: 1/26/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
FORM SH 900.1

2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME: Operations - Plant operations	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS: 455 First Ave, Rm 047	AVERAGE NUMBER OF EMPLOYEES: 37
CITY, STATE, ZIP CODE: New York, NY 10016	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 73840
INDUSTRY DESCRIPTION (e.g., village fire department): NYC Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS): 238220 238210 488999 561720	

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

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

6. CERTIFICATION

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

SIGNATURE: Lera Jackins TITLE: Secretary

PRINT NAME: Lera Jackins DATE: 1-19-05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
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2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of TB Control Surveillance & Education & Training	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 253 Bway Rm 602	AVERAGE NUMBER OF EMPLOYEES 30
CITY, STATE, ZIP CODE New York, NY 10007	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 47060
INDUSTRY DESCRIPTION (e.g.. village fire department) Dept of Health + Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

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

6. CERTIFICATION

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

X SIGNATURE _____ TITLE Surveillance Director

PRINT NAME Fabienne Laraque DATE 1/18/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

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

2004

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"2004" 1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bureau of TB Control CORONA CHEST CENTER	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 34-33 Junction Blvd 1st & 2nd Floors	AVERAGE NUMBER OF EMPLOYEES 44
CITY, STATE, ZIP CODE Jackson Hts., NY 11372	
INDUSTRY DESCRIPTION (e.g.. village fire department) NYC Dept of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 60,700
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621399	

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

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

6. CERTIFICATION

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

SIGNATURE Liz Santana TITLE Admin Manager

PRINT NAME LIZ SANTANA DATE 1/19/05

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
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SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES
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2004

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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME Bronx Regional Office / Early Intervention Program	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS 1932 Arthur Ave. Suite 203B	AVERAGE NUMBER OF EMPLOYEES 42
CITY, STATE, ZIP CODE Bronx, New York 10457	
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Department of Health & Mental Hygiene	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 64,229
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 624190	

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESSES TYPES	
DEATHS	0 (Col. G.)	AWAY FROM WORK	17 (Col. K.)	INJURIES	1 (Col. 1)
DAYS AWAY FROM WORK	1 (Col. H.)	JOB TRANSFER OR RESTRICTION	0 (Col. L.)	SKIN DISORDERS	0 (Col. 2)
JOB TRANSFER OR RESTRICTION	0 (Col. I.)			RESPIRATORY CONDITIONS	0 (Col. 3)
OTHER RECORD-ABLE CASES	0 (Col. J.)			POISONINGS	0 (Col. 4)
				HEARING LOSS	0 (Col. 5)
				ALL OTHER ILLNESSES	0 (Col. 6)

6. CERTIFICATION

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

SIGNATURE _____ TITLE Regional Director

PRINT NAME Janice Chisholm DATE 1/21/04

SH 900.1 (12-03)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Division of Safety and Health
Public Employee Safety and Health Bureau
State Office Campus
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1. ESTABLISHMENT INFORMATION	2. EMPLOYENT INFORMATION
ESTABLISHMENT NAME ORAL HEALTH PROGRAMS & POLICY FOR NEW YORK CITY	If you don't have accurate figures, see the Instructions on the back of the sheet.
STREET ADDRESS REGION-3 120-34 QUEENS BLVD., ROOM# 419	AVERAGE NUMBER OF EMPLOYEES 17
CITY, STATE, ZIP CODE KEW GARDENS, NEW YORK, N.Y. - 11415	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR 20,540
INDUSTRY DESCRIPTION (e.g.. village fire department) New York City Dept of Health & Mental Hygiene	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) 923120 621210.	

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

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

6. CERTIFICATION

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

SIGNATURE Stephens R. Kumar TITLE REGIONAL ADMINISTRATIVE DIRECTOR

PRINT NAME STEPHENS R. KUMAR DATE 1/21/2005

SH 900.1 (12-03)