



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

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

| 3. NUMBER OF CASES  | 4. NUMBER OF DAYS   | 10. INJURIES AND ILLNESSES TYPES  |
|---|---|---|
| <b>DEATHS</b> _____<br>(Col. G.)<br><b>DAYS AWAY FROM WORK</b> _____<br>(Col. H.)<br><b>JOB TRANSFER OR RESTRICTION</b> _____<br>(Col. I.)<br><b>OTHER RECORD-ABLE CASES</b> _____<br>(Col. J.) | <b>AWAY FROM WORK</b> _____<br>(Col. K.)<br><b>JOB TRANSFER OR RESTRICTION</b> _____<br>(Col. L.) | <b>INJURIES</b> _____<br>(Col. 1)<br><b>SKIN DISORDERS</b> _____<br>(Col. 2)<br><b>RESPIRATORY CONDITIONS</b> _____<br>(Col. 3)<br><b>POISONINGS</b> _____<br>(Col. 4)<br><b>HEARING LOSS</b> _____<br>(Col. 5)<br><b>ALL OTHER ILLNESSES</b> _____<br>(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. |                    |
| <b>SIGNATURE</b> _____  | <b>TITLE</b> _____ |
| <b>PRINT NAME</b> _____   | <b>DATE</b> _____  |

ADDITIONAL FORMS AND INFORMATION: If you require additional forms or information concerning the completion of this form, contact: The Office of Occupational Safety and Health at (718) 935-2319

## CALCULATING EMPLOYMENT INFORMATION (Section 2)

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

### Average Number of Employees

1. Add the total number of employees paid in all pay periods for the year. \_\_\_\_\_ ( a )  
Include all full-time, part-time, temporary, seasonal, salaried, and hourly Employees.
2. Count the number of pay periods for the year, including pay periods \_\_\_\_\_ ( b )  
with no employees.
3. Divide the number of employees by the number of pay periods.  $\frac{\text{_____}}{\text{a}} / \frac{\text{_____}}{\text{b}}$  \_\_\_\_\_ ( c )
4. Round the answer to the next whole number. Enter this number \_\_\_\_\_ ( d )  
in the line for "Annual average number of employees" in items 2 on the front.

### Total Hours Worked By All Employees

1. Enter the number of full-time employees in your establishment \_\_\_\_\_ ( e )  
for the year.
2. Enter the number of work hours for a full time employee \_\_\_\_\_ ( f )  
in a year.
3. Multiply (e) by (f) to find the number of full-time hours worked. **X** \_\_\_\_\_ ( g )
4. Add number of overtime hours and number of hours worked by \_\_\_\_\_ ( h )  
other employees (part-time, temporary, seasonal). **+**
5. Round the answer to the next highest whole number. Enter this \_\_\_\_\_ ( i )  
number in the lines for "Total Hours Worked by All Employees  
Last Year" in Item 2 on the front.