NEW YORK STATE - DEPARTMENT OF LABOR
INJURY AND ILLNESS INCIDENT REPORT

FORM SH 900.2

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and PESH develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to 12NYCRR Part 801, PESH recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____

Title _____

Phone (___)_____**Date** _____/_____/_____

Employee Information:

1) Full name _____

2) Street _____

City _____ State _____ Zip _____

3) Date of birth _____/_____/_____ 4) Date hired _____/_____/_____

5) ☐ Male ☐ Female

Physician/Health Care Professional Information:

6) Name of physician or other health care professional _____

_____

7) If treatment was given away from the worksite, where was it given?

Facility _____

Street _____

City _____ State _____ Zip _____

8) Was employee treated in an emergency room?
☐ Yes ☐ No

9) Was employee hospitalized overnight?
☐ Yes ☐ No

Information about the case:

10) Case number from the *Log* _____
(Transfer the case number from the Log after you record the case.)

11) Date of injury or illness _____/_____/_____

12) Time employee began work _____ AM / PM

13) Time of event _____ AM / PM

☐ Check if time cannot be determined

Event occurred ☐ before ☐ during ☐ after work shift

14) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials", "spraying chlorine from hand sprayer."

15) **What happened?** Tell us how the injury occurred. *Examples*: "When ladder slipped on wet floor, worker fell 20 feet", "Worker was sprayed with chlorine when gasket broke during replacement."

16) **What was the injury or illness?** Tell us the part of the body that was affected; be more specific than "hurt", "pain", or "sore." *Examples*: "strained back", "chemical burn, hand."

17) **What object or substance directly harmed the employee:** *Examples*: "concrete floor", "radial arm saw", "chlorine."

18) **If the employee died, when did death occur?** Date of death _____/_____/_____

ILLNESS CASES ONLY ☐ Check this box if the employee independently and voluntarily requests that his or her name not be entered on the log. If checked, treat as a privacy concern case.