



State of New York
Department of Labor
Log of Work Related Injuries and Illnesses
Form SH-900

Political Subdivision (Employer) Town of Athens
Establishment Name 2 First Street
Street Address ATHENS
City NY State NY Zip Code 12015

Calendar Year 20 13
Page 1 of 1

- This form is required by the Commissioner of Labor's Rules and Regulations that record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria found in 12 NYCRR 801.7 - 801.12 and instructions.
- You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria found in 12 NYCRR 801.7 - 801.12 and instructions.
- Use more than one line for a single case if necessary.

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. Refer to the instructions (SH-901) for types of illness and injuries defined as privacy concern cases.

A. Case No.	B. Employee Name	C. Job Title	D. Date of Injury or Onset of Illness (Mo./day)	E. Where the Event Occurred (e.g., Loading dock, north end)	F. Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g., Second degree burns on right forearm from acetylene torch)	Using these categories, check ONLY the most serious result for each case.			Enter No. of Days Injured or Ill Worker Was:		M. Check the Injury Column or Check One Type of Illness
						G. Days Away from Work	Remained at Work	H. Other Restrictible Cases	I. Avg Days from Restriction	J. Other Restriction	
					NO INJURIES OR ILLNESSES						
TOTALS											

Thomas of Athens

ADDITIONAL FORMS AND INFORMATION: If you require additional forms or information concerning the completion of this form, contact:
New York State Department of Labor, Division of Research and Statistics, 4th Floor, 247 West 54th St., New York, NY 10019.
Telephone (212) 621-9380.
SH 900 (3-05)



JOE COPY

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

Calendar Year 2013

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

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

1. ESTABLISHMENT INFORMATION		2. EMPLOYMENT INFORMATION	
ESTABLISHMENT NAME <u>TOWN OF ATHENS</u>		If you don't have accurate figures, see the instructions on the back of this sheet.	
STREET ADDRESS <u>2 FIRST STREET</u>			
CITY, STATE, ZIP CODE <u>ATHENS, NY 12051</u>		AVERAGE NUMBER OF EMPLOYEES <u>18</u>	
INDUSTRY DESCRIPTION (e.g., village fire department) <u>MUNICIPALITY</u>		TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR <u>28,897</u>	
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS) <u>921100</u>			

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

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESS TYPES	
DEATHS	<u>-0-</u> (Col. G)	AWAY FROM WORK	<u>-0-</u> (Col. K)	INJURIES	<u>-0-</u> (Col. 1)
DAYS AWAY FROM WORK	<u>-0-</u> (Col. H)	JOB TRANSFER OR RESTRICTION	<u>-0-</u> (Col. L)	SKIN DISORDERS	<u>-0-</u> (Col. 2)
JOB TRANSFER OR RESTRICTION	<u>-0-</u> (Col. I)			RESPIRATORY CONDITIONS	<u>-0-</u> (Col. 3)
OTHER RECORDABLE CASES	<u>-0-</u> (Col. J)			POISONINGS	<u>-0-</u> (Col. 4)
				HEARING LOSS	<u>-0-</u> (Col. 5)
				ALL OTHER ILLNESSES	<u>-0-</u> (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	<u>Michael Strenka</u>	TITLE	<u>Bookkeeper</u>
PRINT NAME	<u>MICHAEL STRENKA</u>	DATE	<u>4-14-13</u>

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. Include all full-time, part-time, temporary, seasonal, salaried, and hourly employees. 468 (a)
2. Count the number of pay periods for the year, including pay periods with no employees. 26 (b)
3. Divide the number of employees by the number of pay periods. $\frac{468}{a}, \frac{26}{b}$ 18 (c)
4. Round the answer to the next whole number. Enter this number in the line for "Annual average number of employees" in Item 2 on the front. 18 (d)

Total Hours Worked By All Employees

1. Enter the number of full-time employees in your establishment for the year. 12 (e)
2. Enter the number of work hours for a full-time employee in a year. 1933.25 (f)
3. Multiply (e) by (f) to find the number of full-time hours worked. $\times \frac{23,199}{(g)}$
4. Add number of overtime hours and number of hours worked by other employees (part-time, temporary, seasonal). $+ \frac{5,698}{(h)}$
5. Round the answer to the next highest whole number. Enter this number in the lines for "Total Hours Worked by All Employees Last Year" in Item 2 on the front. 28,897 (i)