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

Calendar Year 2011

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: SUNY DOWNSTATE MEDICAL CENTER	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS: 450 CLARKSON AVE.	AVERAGE NUMBER OF EMPLOYEES: 5,022
CITY, STATE, ZIP CODE: BROOKLYN, NY 11203	
INDUSTRY DESCRIPTION (e.g.,village fire department): STATE UNIVERSITY HOSPITAL	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR: 10,062,302
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)	AWAY FROM WORK	1674 (Col. K)	INJURIES	212 (Col.1)
DAYS AWAY FROM WORK	53 (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	160 (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 _____

PRINT NAME _____ DATE _____