

CENTER FOR ENVIRONMENTAL HEALTH

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Public Health
Prevent. Promote. Protect.

EDWIN J. DAY
County Executive

SAMUEL RULLI, PE
Director, Environmental Health

INJURY AND ILLNESS REPORT

A full report of specific injuries or illnesses occurring as a result of using an ultraviolet radiation device shall be made by the operator to the Department of Health within twenty-four (24) hours of notification of its occurrence. Reportable injuries and illnesses shall include: (1) all eye injuries requiring medical attention; (2) all burns requiring medical attention; (3) any other injury or illness incident resulting from the use of an ultraviolet radiation device for which medical care has been obtained. Forms shall be maintained at the tanning facility for a minimum of three (3) years and must be available for review by the Department of Health.

Facility Information

Facility Name: _____

Name of Operator: _____

Type of Facility: Tanning Only Salon/Spa Fitness Other

Client Information

Name of Client (Last, First, Middle): _____

Home Address: _____

Name of Parent or Legal Guardian (Last, First, Middle): _____

Home Telephone Number: (____) ____ - _____

Age of Client (years): ____ Sex: Female Male

Event Information

Type of Incident: Injury Illness

Date of Incident/Onset ____/____/____ Time of Occurrence/Onset ____:____ AM PM

Location where incident occurred: Tanning Bed Tanning Booth Other _____

Nature of incident: _____

Part of body injured: _____

Duration of Tanning Exposure: _____

Date client reported incident: ____/____/____ Time client reported incident: ____:____ AM PM

Medical attention: Yes No

Name of Physician: _____ Telephone Number: (____) ____ - _____

Address of Physician: _____

Diagnosis/Treatment: _____

Equipment Information

Manufacturer of the tanning device: _____

Model: _____ Model Number: _____

Date of manufacture: _____ Serial Number: _____

Types of lamps used in the tanning device: _____

Information received by: _____ Date: ____/____/____

Title of person reporting the incident: _____