

# New York State Department of Health

Bureau of Community Environmental Health and Food Protection  
Tanning Facilities Program

# Injury and Illness Report Form

Incident Log Number: \_\_\_\_\_

A full report of specific injuries or illnesses occurring as a result of using an ultraviolet radiation (tanning) device shall be made by the operator to the Permit Issuing Official (PIO) 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 two (2) years and must be available for review by the PIO.

## Facility Information

Facility Name: \_\_\_\_\_ Name of Operator: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Facility Telephone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Type of Facility:  Tanning Only  Salon/Spa  Fitness  Other

## Client Information

Name (Last, First, Middle): \_\_\_\_\_

Home Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Age (years): \_\_\_\_\_ Gender:  Female  Male

Tanning frequency (3 month history):  First time tanning  Between 2 and 9 sessions  10 or more sessions

Name of Parent or Legal Guardian for minors (Last, First, Middle): \_\_\_\_\_

## Event Information

Specific injury or illness requiring medical attention:  Eye injury  Burn  Any other injury or illness incident

Area(s) of injury:	Description of illness:
<input type="checkbox"/> Head <input type="checkbox"/> Arm <input type="checkbox"/> Chest <input type="checkbox"/> Leg <input type="checkbox"/> Face <input type="checkbox"/> Wrist <input type="checkbox"/> Abdomen <input type="checkbox"/> Ankle <input type="checkbox"/> Eye <input type="checkbox"/> Hand <input type="checkbox"/> Back <input type="checkbox"/> Foot <input type="checkbox"/> Neck <input type="checkbox"/> Finger <input type="checkbox"/> Shoulder  <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Acute illness or disease* <input type="checkbox"/> Chronic illness or disease* <input type="checkbox"/> Allergic reaction* <input type="checkbox"/> Dehydration <input type="checkbox"/> Anaphylactic shock* <input type="checkbox"/> Infection* <input type="checkbox"/> Cardiac <input type="checkbox"/> Other*  *Specify: _____

Date of incident/onset: \_\_\_/\_\_\_/\_\_\_ Time of occurrence/onset: \_\_\_:\_\_\_  AM  PM

Location where incident occurred:  Tanning Bed  Tanning Booth  Other \_\_\_\_\_

Duration of tanning exposure: \_\_\_\_\_ Nature of incident: \_\_\_\_\_

Date client reported incident: \_\_\_/\_\_\_/\_\_\_ Time client reported incident: \_\_\_:\_\_\_  AM  PM

Name of medical provider: \_\_\_\_\_ Date of medical treatment: \_\_\_/\_\_\_/\_\_\_

Reported diagnosis/treatment: \_\_\_\_\_

Follow up for incident: \_\_\_\_\_

## Equipment Information

Manufacturer of the tanning device: \_\_\_\_\_ Date of manufacture: \_\_\_\_\_

Model: \_\_\_\_\_ Model Number: \_\_\_\_\_ Serial Number: \_\_\_\_\_

Types of lamps used in the tanning device: \_\_\_\_\_

Information received by: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_