

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 device shall be made by the operator to the PIO (permit issuing official) 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 of Client (Last, First, Middle): _____

Home Address: _____ Telephone Number: (____) ____-____

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

Age of Client (years): _____ Gender of Client: Female Male

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

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"/> 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*
<input type="checkbox"/> Other, specify: _____	*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: ___/___/___