



EMPLOYEE PERSONAL INJURY/OCCUPATIONAL ILLNESS REPORT

Each employee incurring an injury or occupational illness on duty and/or on property that requires medical attention must fill out this report and provide it to their supervisor. * A copy should be retained for your file.

NAME OF INJURED PERSON		AGE	DATE OF BIRTH	SENIORITY DATE	EMPLOYEE ID NUMBER
ADDRESS OF INJURED PERSON (STREET, CITY, ZIP CODE)					TELEPHONE NUMBER ()
LOCATION OF INJURY (CITY AND STATE)		MILE POST (IF APPLICABLE)	STATION NO. (IF APPLICABLE)	DATE OF INJURY	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM
TEMPERATURE	VISIBILITY (Check correct response) <input type="checkbox"/> DAWN <input type="checkbox"/> DUSK <input type="checkbox"/> DAY <input type="checkbox"/> DARK		WEATHER (Check correct response) <input type="checkbox"/> CLEAR <input type="checkbox"/> RAIN <input type="checkbox"/> SLEET <input type="checkbox"/> CLOUDY <input type="checkbox"/> FOG <input type="checkbox"/> SNOW		
IF THIS IS AN OCCUPATIONAL ILLNESS RATHER THAN AN ACUTE INJURY, WHEN DID YOU FIRST NOTICE SYMPTOMS?			WHEN WERE YOU FIRST TREATED OR DIAGNOSED?		
DESCRIBE INJURIES OR OCCUPATIONAL ILLNESS (attach additional pages if necessary):					
DESCRIBE FULLY HOW INJURY OR OCCUPATIONAL ILLNESS OCCURRED (attach additional pages if necessary):					
WAS THE ACCIDENT CAUSED BY THE CONDUCT OF ANOTHER PERSON? <input type="checkbox"/> Yes <input type="checkbox"/> No			IF YES, PLEASE DESCRIBE:		
COULD YOU, BY MORE CARE ON YOUR PART, HAVE PREVENTED YOUR INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No			IF YES, HOW?		
WAS THERE ANYTHING WRONG WITH THE EQUIPMENT, WORK PROCEDURES, OR WORK AREA WHICH LED TO THIS ACCIDENT/INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No			IF YES, PLEASE DESCRIBE:		
TYPE OF MEDICAL ATTENTION ADMINISTERED (PRESCRIPTION, BRACE, SPLINT, ETC):					
NAME OF ATTENDING PHYSICIAN:			ADDRESS:		
NAME OF ATTENDING FACILITY:			ADDRESS:		
IF INJURY OCCURRED WHILE WORKING WITH ON TRACK EQUIPMENT, LIST INITIALS AND NUMBERS:					
IMPORTANT: LIST ALL PERSONS WHO WITNESSED THE INJURY OR THAT CAN GIVE ANY INFORMATION ABOUT IT:					
NAME		OCCUPATION		ADDRESS (Show Street and City)	
Signed				Date	

PLEASE ANSWER ALL QUESTIONS (USE REVERSE SIDE IF NECESSARY)

* See Injury Handling and Safety Reporting policy if necessary.

REPORT PREPARED TO COMPLY WITH FEDERAL ACCIDENT REPORTING REQUIREMENTS
AND PROTECTED FROM DISCLOSURE PURSUANT TO 49 U.S.C. 20903 AND 83 U.S.C. 490