

KANSAS CITY SOUTHERN RAILWAY / GATEWAY WESTERN RAILROAD / GATEWAY EASTERN RAILROAD

REPORT NO.

68-D EMPLOYEE REPORT OF INJURY AND ILLNESS

1007950

48.0001.201

revised 11/99

All questions must be printed by the injured employee in his/her own handwriting, as soon as possible after an on or off duty injury/illness occurs. If unable to complete the report, another person may transcribe exactly the employee's wording. It must be noted on the form that it was completed at the employee's request, and employee's signature must be secured on form. This form must be forwarded to the immediate supervisor before tour of duty is complete. Supervisor must fill out a Manager's Report of Employee Injury or Illness, fax it along with this report to the numbers listed at bottom and then mail originals to the Accident Reporting Office, 4601 Shreveport-Blanchard Highway, Shreveport, LA 71107-5797.

1. FULL NAME OF INJURED EMPLOYEE: (First, MI, Last)		2. DATE HIRED:		3. SOC. SEC. NO.:	
4. ADDRESS OF INJURED EMPLOYEE (Street, City, State, Zip):				5. HOME PHONE NO.: ()	
6. OCCUPATION:		7. DEPARTMENT:		8. SEX: <input type="checkbox"/> M <input type="checkbox"/> F	
9. DATE OF BIRTH:					
10. ADDRESS WHERE EMPLOYEE NORMALLY REPORTS FOR DUTY (Street, City, State, Zip):					
11. DATE OF INJURY		12. TIME OF INJURY: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		13. TIME SHIFT BEGAN: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
14. SCHEDULED REST DAYS (all that apply): <input type="checkbox"/> Su <input type="checkbox"/> M <input type="checkbox"/> Tu <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa <input type="checkbox"/> None		15. FUTURE VACATION DAYS SCHEDULED PRIOR TO THIS INJURY:			
16. LOCATION WHERE INJURY OCCURRED (Street, Track, Building, etc.):					
17. NEAREST MILEPOST (if applicable) <input type="checkbox"/> Main Track <input type="checkbox"/> Yard		18. CITY:		19. COUNTY/PARISH:	
20. STATE & ZIP:					
21. WEATHER CONDITIONS: <input type="checkbox"/> Clear <input type="checkbox"/> Rain <input type="checkbox"/> Sleet <input type="checkbox"/> Other (Explain) <input type="checkbox"/> Cloudy <input type="checkbox"/> Snow <input type="checkbox"/> Fog			22. VISIBILITY: <input type="checkbox"/> Daylight <input type="checkbox"/> Dawn <input type="checkbox"/> Artificial Lighting <input type="checkbox"/> Dark <input type="checkbox"/> Dusk		
23. WHAT JOB OR ACTIVITY WAS BEING PERFORMED AT TIME OF INJURY:					
24. DESCRIBE INJURY/ILLNESS AND ALL BODY PARTS AFFECTED:					
25. HOW DID INJURY OCCUR? (include a sequence of events leading up to injury) Use back if necessary:					
26. LIST INITIAL AND NUMBER OF ANY CARS, LOCOMOTIVES OR EQUIPMENT INVOLVED:					
27. DID YOU COME IN DIRECT CONTACT WITH A LEAK OR SPILL OF HAZARDOUS MATERIAL, CHEMICAL OR SUBSTANCE: <input type="checkbox"/> Yes <input type="checkbox"/> No					
IF YES, LIST HAZARDOUS MATERIAL, CHEMICAL OR SUBSTANCE:					
28. WERE YOU EXAMINED BY A DOCTOR? <input type="checkbox"/> Yes <input type="checkbox"/> No		DOCTOR'S ADDRESS:			
DOCTOR'S NAME:					
29. LIST CREW OR GANG MEMBERS (Use back if necessary):					
30. LIST WITNESSES (Name, Address & Phone) (Use back if necessary):					
31. 65-D HIGHWAY-RAIL GRADE CROSSING INCIDENT NUMBER (if applicable):			32. 66-D RAIL EQUIPMENT ACCIDENT REPORT NUMBER (if applicable):		
33. NAME OF EMPLOYEE COMPLETING REPORT:					
34. DATE AND TIME THAT YOU NOTIFIED COMPANY OF THIS INCIDENT:			35. WHO DID YOU NOTIFY OF THIS INCIDENT?:		
36. SIGNATURE OF INJURED EMPLOYEE:				37. DATE REPORT COMPLETED:	
Supervisor fax distribution: <input type="checkbox"/> Safety (318) 676-6459 <input type="checkbox"/> Claims (318) 676-6144 <input type="checkbox"/> HR (816) 983-1662 <input type="checkbox"/> KC Safety/Environmental (816) 983-1622					