

PERSONAL INJURY REPORT

REPORT DATE: _____ DEPARTMENT _____
REPORT TIME (_____ AM) or (_____ PM) _____ DIVISION _____

Train No. (if applicable) _____ Is this incident related to a Train or Crossing Accident? Yes No

TO: Supervisory Officer: _____ FROM: Injured Employee: _____ Employee SS No.: _____

INCIDENT DATE: _____ INCIDENT TIME: (_____ AM) or (_____ PM)

LOCATION: Select one: Line of Road _____ Terminal _____ Shop or Office Building _____ Off Railroad Property _____

INCIDENT CITY: _____ STATE: _____ MILEPOST: (if applicable) _____

WEATHER: Select one: Clear _____ Cloudy _____ Rain _____ Fog _____ Sleet _____ Snow _____ Does Not Apply _____ (Injury Occurred Indoors)

VISIBILITY: Select one: Dawn _____ Day _____ Dusk _____ Dark _____ Indoors-Dark _____ Indoors-Dim _____ Indoors-Normal _____ Indoors-Other _____

TEMPERATURE: (_____ PLUS) or (_____ MINUS)

HEIGHT: _____ FT. _____ IN. WEIGHT _____ LBS. OCCUPATION _____

REST DAYS: Select all that apply: Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____ Sunday _____ None _____

ASSIGNMENT: REGULAR _____ RELIEF _____ EXTRA _____

ON DUTY: Yes No HOURS ON DUTY AT TIME OF INCIDENT _____

SAFETY ATTIRE WORN: Select all that apply: Head _____ Eye _____ Hearing _____ Respiratory _____ Foot _____ Hand _____ Other _____ None _____

WAS ANY TYPE OF EQUIPMENT INVOLVED? Yes No STATIONARY _____ MOVING _____

EQUIPMENT TYPE: Select one: Freight _____ Passenger _____ Mixed _____ Work _____ Yard Switching _____ Light Locomotive _____ M/W Equipment _____ None _____

INITIAL AND NUMBER: _____

WITNESS NAMES

ADDRESSES

DO YOU DESIRE MEDICAL ATTENTION AT THIS TIME? Yes No

DESCRIBE WHAT HAPPENED - GIVE SPECIFIC, DETAILED INFORMATION: _____

