

REPORT OF EMPLOYEE PERSONAL INJURY ILLNESS/INCIDENT

MENU IS THIS RELATED TO A REPORTABLE TRAIN OR CROSSING ACCIDENT? NO _____ CROSSING _____ TRAIN _____ (Over Rptng Threshold)

EMPLOYEE EIN _____ RELATED TO REPORT NO. _____

EMPLOYEE NAME _____ (Name Computer Generated by EIN onto Screen 1 - but enter first name)

(FIRST) (MIDDLE) (LAST)

SCREEN 1 - LOCATION AND EMPLOYEE

INCIDENT NUMBER _____ (Computer Generated)

INCIDENT DATE ____/____/____ TIME: ____:____ AM PM

COMPANY * _____ DEPARTMENT* _____

DIVISION * _____ FACILITY* _____ CHRGT TO* _____

LOCATION * (Select One): LINE OF ROAD _____ TERMINAL _____ SHOP OR OFFICE BUILDING _____ OFF RAILROAD PROPERTY _____ MILEPOST _____

INCIDENT CITY _____ COUNTY _____ STATE _____ ZIP _____

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 _____ MINUS _____ GENDER: Male _____ Female _____

HEIGHT: _____ FT. _____ IN. WEIGHT: _____ LBS. EMPLOYEE RIN NUMBER _____ JOB * _____

REST DAYS * (Select All That Apply): MONDAY _____ TUESDAY _____ WEDNESDAY _____ THURSDAY _____ FRIDAY _____ SATURDAY _____ SUNDAY _____ NONE _____

ASSIGNMENT: REGULAR _____ RELIEF _____ EXTRA _____ MONTHS IN AREA OR ON ASSIGNMENT _____

ON DUTY? YES _____ NO _____ EXPOSURE TO HAZMAT? YES _____ NO _____ ON COMPANY PROPERTY? YES _____ NO _____

HOURS ON DUTY AT TIME OF INCIDENT _____ REST HOURS PRIOR TO THIS TOUR OF DUTY _____

AT COMPANY-SPONSORED EVENT OR IN COMPANY PROVIDED TRANSPORTATION: YES _____ NO _____

EMPLOYEE NOTIFIED COMPANY: DATE ____/____/____ PERSON NOTIFIED: _____ TIME: ____:____ AM PM

SUPERVISOR'S EIN: _____ NAME _____ (Computer Generated by EIN)

SCREEN 2 - INJURY AND TREATMENT

ACCIDENT TYPE * _____ BODY PART * _____

INJURY TYPE * _____ ACTIVITY * _____

OBJECT OF ACTIVITY * _____ SOURCE OF INJURY * _____

SAFETY ATTIRE WORN * (Select All That Apply): HARD HAT _____ EYE _____ HEARING _____ RESPIRATORY _____ FOOT _____ HAND _____ OTHER _____ NONE _____

NAME BRAND OF EYE PROTECTION WORN: * _____

WAS ANY TYPE OF EQUIPMENT INVOLVED? _____ (Y or N) STATIONARY _____ MOVING _____

EQUIPMENT TYPE * (Select One): FRIEGHT _____ PASSENGER _____ MIXED _____ WORK _____ YARD/SWITCHING _____ LIGHT LOCO _____ M/W EQUIPMENT _____ NONE _____

INIT. AND NUMBER: _____ SHOP _____ OTHER _____

WAS EQUIPMENT DEFECTIVE? _____ (Y or N) IF YES, HOW _____

TYPE OF MEDICAL ATTENTION * (Select One): DECLINED TREATMENT _____ FIRST AID _____ PRESCRIPTION (FRA Reportable) _____ MEDICAL TREATMENT (FRA Reportable) _____

DESCRIBE TREATMENT RENDERED: _____

PROVIDER _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

DISABILITY: NONE _____ RESTRICTED ACTIVITY _____ LOST TIME _____ PERMANENT _____

RESTRICTED ACTIVITY: BEGIN DATE ____/____/____ END DATE ____/____/____ DAYS _____ ACT _____ EST _____

LOST TIME: BEGIN DATE ____/____/____ END DATE ____/____/____ DAYS _____ ACT _____ EST _____

PERMANENT: DEATH _____ TERMINATED _____ TRANSFER _____ EFFECTIVE DATE ____/____/____

SCREEN 2A - CIRCUMSTANCE CODES (Entries Will Be Selected By Department Based Upon Content Of This Form)

FORCE ACCOUNT SECTION

IS THIS INJURY ASSOCIATED WITH FORCE ACCOUNT WORK? _____ (Y or N)

(WORK PERFORMED FOR 3RD PARTIES WHERE THE COST OF THE WORK IS REIMBURSED)

SCREEN 3 - INCIDENT DESCRIPTIONS

EMPLOYEE'S DESCRIPTION OF INCIDENT: _____

SUPERVISOR'S DESCRIPTION OF INCIDENT: _____

SCREEN 3A - SPECIAL CAPTURE CODES / COVERED DATA:

____ PRESCRIBED TIME OFF, BUT NO DAYS WERE ACTUALLY TAKEN (TYPE A)
 ____ PRESCRIBED RESTRICTION OF ROUTINE WORK DUTIES, (TYPE R)
 BUT RESTRICTION DID NOT OCCUR
 ____ PRESCRIBED OTC MEDICATION AT PRESCRIPTION STRENGTH, (TYPE P)
 OR SINGLE EXTERNAL APPLICATION OF PRESCRIPTION MEDICATION

NOTE: CHECK ALL THAT APPLY - TYPE PRECEDENCE = (TYPE A < TYPE R < TYPE P)

LONGITUDE (OPITONAL)

____ DEGREES (066 - 098) _____ DECIMAL (000000 - 999999)

LATITUDE (OPITONAL)

____ DEGREES (024 - 049) _____ DECIMAL (000000 - 999999)

SCREEN 4 - TESTING AND WITNESSES

TYPE OF DRUG TESTS ADMINISTERED NONE _____ BLOOD _____ URINE _____ BOTH _____

TYPE OF ALCOHOL TESTS ADMINISTERED NONE _____ BLOOD _____ BREATH _____ BOTH _____

WITNESSES (If Employee: ENTER ONLY NAME, EIN AND TELEPHONE NUMBER)

NAME _____ EIN _____ TELEPHONE _____ - _____ - _____
 ADDRESS _____ CITY _____ ST _____ ZIP _____

NAME _____ EIN _____ TELEPHONE _____ - _____ - _____
 ADDRESS _____ CITY _____ ST _____ ZIP _____

NAME _____ EIN _____ TELEPHONE _____ - _____ - _____
 ADDRESS _____ CITY _____ ST _____ ZIP _____

Copies of Injury Report will be automatically sent to Safety, Casualty Claims - Norfolk and Medical Departments.

(ENTER MESSAGE SWITCHING ADDRESSES FOR DISTRICT CLAIM AGENT, LOCAL CLAIM AGENT, AND APPROPRIATE SUPERVISORS OR SEVEN-CHARACTER TCAM PRINTER ID:)

1 _____ MSG ADDR _____	2 _____ MSG ADDR _____
3 _____ MSG ADDR _____	4 _____ MSG ADDR _____
5 _____ MSG ADDR _____	6 _____ MSG ADDR _____

SCREEN 5 - SUMMARY

WORKSHEET COMPLETED BY _____ TITLE _____ DATE ____/____/____

* Asterisk indicates that entry corresponds with selection table in computer. Six computer screens must be completed to transmit. Computer access - 1) Thoroughbred Screen: Select R (IDMS), type in user ID & password; QR; Netview Access Screen: Type in user ID, password, & Group (UCRGRP); select application IDMS. 2) type the word INJURY at ENTER NEXT TASK CODE, select MENU option. Help screens available in computer program.

COMPLETE ALL ITEMS