



EMPLOYEE PERSONAL INJURY/OCCUPATIONAL ILLNESS REPORT

Each employee incurring an injury or occupational illness on duty and/or on property 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	SOCIAL SECURITY 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"/> CLOUD	<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:					
DESCRIBE FULLY HOW INJURY OR OCCUPATIONAL ILLNESS OCCURRED:					
WAS THE ACCIDENT CAUSED BY THE CONDUCT OF ANOTHER PERSON?			IF YES, PLEASE DESCRIBE:		
<input type="checkbox"/> Yes <input type="checkbox"/> No					
COULD YOU, BY MORE CARE ON YOUR PART, HAVE PREVENTED YOUR INJURY?			IF YES, HOW?		
<input type="checkbox"/> Yes <input type="checkbox"/> No					
WAS THERE ANYTHING WRONG WITH THE EQUIPMENT, WORK PROCEDURES, OR WORK AREA WHICH LED TO THIS ACCIDENT / INJURY?			IF YES, PLEASE DESCRIBE:		
<input type="checkbox"/> Yes <input type="checkbox"/> No					
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)