

## PERSONAL INJURY REPORT

REPORT DATE:	DEPARTMENT
REPORT TIME (AM) or (PM)	DIVISION
TRAIN NO. (If applicable) Is this incident re	elated to a Train or Crossing Accident? [ ] Yes [ ] No
TO: Supervisory FROM: Injured Employee:	Employee ID 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 VISIBILITY: Select one: Dawn Day Dusk Dark Indoors-Dark _ TEMPERATURE: ( PLUS) or ( MINUS)	
HEIGHT: FT IN. WEIGHT LBS. OCC	UPATION
REST DAYS: Select all that apply: Monday Tuesday Nednesday 1  ASSIGNMENT: REGULAR RELIEF EXTRA ON DUTY: [ ] Yes [ ] No HOURS ON DUTY AT TIME OF	<u> </u>
SAFETY ATTIRE WORN: Select all that apply: Head Eye Hearing _	
WAS ANY TYPE OF EQUIPMENT INVOLVED? [ ] Yes [ ] No	
EQUIPMENT TYPE: Select One: Freight Passenger Mixed Work INITIAL AND NUMBER:	Yard Switching Light Locos M/W EquipmentNone
WITNESS NAMES	ADDRESSES
DO YOU DESIRE MEDICAL ATTENTION AT THIS TIME? [ ] Yes [ DESCRIBE WHAT HAPPENED – GIVE SPECIFIC, DETAILED INFORMATIO	
SIGN	ATURE OF EMPLOYEE

Distribution:

Original to Supervisory Officer Photocopy to Injured