INCIDENT NUMBER	EMPLOYEE NAME	ID NUMBER	SOCIAL SECURITY NO.
01	02	03	04

ADDRESS ( )

05 (Street Address) (City) (State) (Zip Code) (Phone No.)

DATE OF BIRTH Mo. Day Yr.	AGE	OCCUPATION	DEPARTMENT	SUPERVISOR
06	07	08	09	10

DATE HIRED Mo. Day Yr.	NUMBER CONSECUTIVE DAYS WORKED	NUMBER OF HOURS OFF PRIOR TO TOUR OF DUTY
11	12	12a

INCIDENT LOCATION	INCIDENT CITY	INCIDENT COUNTY	INCIDENT STATE
13 (Shop, Plant, Track, Station, Train, Etc.)	14	15	16

MILEPOST (To Nearest Tenth)	DIVISION	INCIDENT DATE Mo. Day Yr.	INCIDENT TIME	VISIBILITY
17	18	19	20 ☐ AM ☐ PM	21 ☐ Dawn ☐ Dusk ☐ Daylight ☐ Dark

WEATHER

22 ☐ Clear ☐ Rain ☐ Sleet ☐ Cloudy ☐ Fog ☐ Snow

NATURE OF COMPLAINT

23

WAS MEDICAL ATTENTION PROVIDED?

24 ☐ Yes ☐ No If Yes, Name and Address of Physician and Medical Facility.

DESCRIBE MEDICAL/FIRST-AID TREATMENT RECEIVED WAS PRESCRIPTION MEDICATION INCLUDED IN TREATMENT? ☐ YES ☐ NO

25

DESCRIBE THE INCIDENT

26

IS THIS A RECURRENCE?

27 ☐ Yes ☐ No

WILL INCIDENT RESULT IN LOST WORKDAYS?

28 ☐ Yes ☐ No No. of Days

WAS ANYONE AT FAULT?

29 ☐ Yes ☐ No If Yes, Who and to What Extent?

DID DEFECTIVE TOOL OR EQUIPMENT CAUSE INCIDENT?

30 ☐ Yes ☐ No If Yes, Describe and Specify Defect.

ADDITIONAL SPACE FOR REPORT INFORMATION

DID EMPLOYEE HAVE A SAFE PLACE IN WHICH TO WORK?

31 ☐ Yes ☐ No If No, Specify the Safety Hazard.

WAS THE WORKPLACE ADEQUATELY LIGHTED?

32 ☐ Yes ☐ No If No, Describe Conditions.

WAS THERE ANY FAILURE TO GIVE USUAL OR NECESSARY SIGNALS, WARNINGS OR PROTECTION?

33 ☐ Yes ☐ No

IF ON-TRACK EQUIPMENT WAS INVOLVED, GIVE INITIALS AND NO'S.

34

LOCATION WHERE EMPLOYEE NORMALLY REPORTS.

NAME OF FACILITY _____

35 STREET | CITY | STATE | ZIP

NAMES AND ADDRESSES OF WITNESSES TO THE INCIDENT

36

EMPLOYEE SIGNATURE

37

WITNESS TO EMPLOYEE SIGNATURE

38

DATE

39

NAME OF SUPERVISOR NOTIFIED

40

MEDICAL INFORMATION RELEASE