



EMPLOYEE PERSONAL INJURY/OCCUPATIONAL ILLNESS REPORT

Each employee reporting an injury, condition or occupational illness on duty and/or on property must fill out this report and provide it to his or her supervisor (pursuant to § 225.19). A copy will be provided upon request.

NAME OF INJURED PERSON		AGE	DATE OF BIRTH	SENIORITY DATE	EMPLOYEE ID NUMBER
ADDRESS OF INJURED PERSON (STREET, CITY, ZIP CODE)					TELEPHONE NUMBER
LOCATION OF INJURY (CITY AND STATE)		MILE POST (IF APPLICABLE)	SUBDIVISION (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/ICE <input type="checkbox"/> CLOUDY <input type="checkbox"/> FOG <input type="checkbox"/> SNOW	
IF THIS IS AN ILLNESS OR CONDITION RATHER THAN AN ACUTE INJURY, WHEN DID YOU FIRST NOTICE SYMPTOMS?			WHEN WERE YOU FIRST TREATED OR DIAGNOSED?		
DESCRIBE INJURIES OR ILLNESS/CONDITION: (attach additional pages if necessary)					
DESCRIBE FULLY HOW INJURY, ILLNESS OR CONDITION OCCURRED: (attach additional pages if necessary)					
WAS THE ACCIDENT CAUSED BY THE CONDUCT OF ANOTHER PERSON?			IF YES, PLEASE DESCRIBE:		
<input type="checkbox"/> Yes <input type="checkbox"/> No					
COULD YOU HAVE PREVENTED YOUR INJURY?			IF YES, HOW?		
<input type="checkbox"/> Yes <input type="checkbox"/> No					
WAS THERE ANY DEFECT/MALFUNCTION/PROBLEM OR WITH THE EQUIPMENT OR WORK PROCEDURES?			IF YES, PLEASE DESCRIBE:		
<input type="checkbox"/> Yes <input type="checkbox"/> No					
TYPE OF MEDICAL ATTENTION ADMINISTERED (PRESCRIPTION, BRACE, SPLINT, ETC):					
NAME OF PHYSICIAN:			ADDRESS:		
NAME OF ATTENDING FACILITY:			ADDRESS:		
SUPERVISOR NAME:		NOTE - If you do not receive medical treatment as the result of this injury or occupational illness, you must promptly notify your supervisor: <ul style="list-style-type: none">• if you experience any complications resulting from your injury/illness.• if you are unable to perform your normal duties or absent yourself from your regular assignment because of this injury/illness.• before visiting a health care professional for subsequent treatment or observation due to your injury.			
IF INJURY OCCURRED WHILE WORKING WITH ON TRACK EQUIPMENT, LIST INITIALS AND NUMBERS:					
IMPORTANT: LIST ALL PERSONS WHO WITNESSED THE INJURY OR WHO CAN GIVE ANY INFORMATION ABOUT IT:					
NAME		OCCUPATION		ADDRESS (Show Street and City)	
Signed				Date	

PLEASE ANSWER ALL QUESTIONS (USE REVERSE SIDE IF NECESSARY)