RAILROAD EMPLOYEE INJURY AND/OR ILLNESS RECORD

DEPARTMENT OF TRANSPORTATION
FEDERAL RAILROAD ADMINISTRATION (FRA)

OMB Approval No.: 2130-0500

1. Railroad	2. Case/Incident Number

EMPLOYEE INFORMATION

3. Last Name, First Name, Middle Initial	4. Date of Birth	5. Sex (M/F)	6. Social Security Number	7. Date Hired

HOME ADDRESS:	8. Street Address *(include Apt. No.)*	9. City	10. State	11. ZIP	12. Home Telephone No. *(include area code)*

ESTABLISHMENT/ FACILITY WHERE EMPLOYEE NORMALLY REPORTS:	13. Name of Facility			
	14. Street Address	15. City	16. State	17. ZIP

18. Job Title	19. Department Assigned To

ACTIVITY/INCIDENT/EXPOSURE DESCRIPTION

LOCATION WHERE ACCIDENT/ INCIDENT/ EXPOSURE OCCURRED:	20. Specific Site			
	21. City	22. County	23. State	24. ZIP

25. Is this on your premises? Yes ☐ No ☐	26. Date of Occurrence	27. Time Shift Began AM ☐ PM ☐	28. Time of Occurrence AM ☐ PM ☐	29. Was person on duty? Yes ☐ No ☐

COMPANY NOTIFICATION:	30. Date that Employee Notified Company Personnel of Condition	31. Time that Employee Notified Company Personnel of Condition AM ☐ PM ☐	32. Person Notified

33. Describe the general activity this person was engaged in prior to injury/illness.

34. Describe all factors associated with this case that are pertinent to an understanding of how it occurred. Include a discussion of the sequence of events leading up to it, and the tools, machinery, processes, material, environmental conditions, etc., involved.

NOTE: This report is part of the reporting railroad's accident report pursuant to the accident reports statute and, as such shall not " be admitted as evidence or used for any purpose in any suit or action for damages growing out of any matter mentioned in said report . . . ." 49 U.S.C. 20903. See 49 C.F.R. 225.7 (b).

INJURY/CONDITION INFORMATION

35. Describe in detail the injury/condition that this person sustained. Include a discussion of the body parts affected. If this is a recurrence, list date of last occurrence.

36. Identify all persons and organizations used to evaluate and/or treat condition. (Include facility, provider, and address)

37. Describe all procedures, medications, therapy, etc., used/recommended for the treatment of condition:

38. Check any of the following consequences resulting from this injury/condition:

- ☐ Death. Date of: _____
- ☐ Restriction of work. Reportable days of restricted activity: _____ as of: _____
- ☐ Occupational illness. Date of initial diagnosis:
- ☐ Instructions to obtain prescription medication, or receipt of prescription medication.
- ☐ Missed a day of work or next shift. Reportable days absent from work: _____ as of: _____
- ☐ Significant injury/illness, one meeting specific case criteria, or a covered data case.
- ☐ Medical treatment. This includes any medical care or treatment beyond "first aid" that is given, or should have been given, regardless of who provided the treatment. "First Aid" treatment is limited to very simple procedures, e.g., application of a bandaid on minor scratches, cuts, abrasions, etc.
- ☐ Transfer to another job or termination of employment.
- ☐ Hospitalization for treatment as an inpatient.
- ☐ Multiple treatments or therapy sessions.
- ☐ Loss of consciousness.

39. If any of the above consequences occurred, the injury/condition is almost always reportable to FRA on Form FRA F 6180.55a. If you believe this case does not meet the reporting criteria, you must give a brief explanation below of the basis for this decision. Was the case reported? Yes ☐ No ☐

40. Has this employee been provided an opportunity to review his or her file? Yes ☐ No ☐

41. Preparer's Name	42. Preparer's Title	43. Telephone Number	44. Date