

HIGHWAY USER INJURY INQUIRY FORM

DEPARTMENT OF TRANSPORTATION
Federal Railroad Administration (FRA)

OMB Approval No. 2130-0500

PART I – Highway Rail-Grade Crossing Accident/Incident (To be completed by reporting railroad)			
1a. Date of Accident/Incident (mm/dd/yyyy)		1b. Time of Accident/Incident <input type="checkbox"/> AM <input type="checkbox"/> PM	
2a. Name of Railroad		2b. Alphabetic Code	3. Railroad Accident/Incident Number
4. U.S. DOT Grade Crossing Identification Number			
5. Highway Name or Number	6. City (if in a city)	7. County	8. State Abbr.
PART II - Highway User Statement (To be completed by highway user or highway user's representative)			
9a. Highway User's Last Name		9b. First Name	9c. Middle Initial
10. Highway User's Age			
11. Highway User's Telephone (Primary)		12. Highway User's Telephone (Secondary)	
13. Highway User's E-mail Address			
14. Highway User's Mailing Address			
15a. Did you suffer an injury, or injuries, as a result of the highway-rail grade accident/incident described above? <input type="checkbox"/> Yes <input type="checkbox"/> No			
15b. Narrative Description: If you answered "Yes" to 15a., please describe the nature and severity of your injury, or injuries, the event(s) that caused the injury, or injuries, and any other relevant information. You may continue the Narrative Description on back of form.			
16a. As a result of your injury, or injuries, caused by the highway rail-grade crossing accident/incident, did you (please check all that apply and complete the Narrative Description in 16b.):			
<input type="checkbox"/> (i) Receive medical treatment beyond first aid (i.e. prescription medication or stitches) <input type="checkbox"/> (ii) Lose consciousness <input type="checkbox"/> (iii) Suffer a fractured or cracked bone, or a punctured eardrum diagnosed by a physician or other licensed health care provider <input type="checkbox"/> (iv) Receive transportation from the highway rail-grade crossing accident/incident to a medical facility via emergency medical transportation (EMT) (i.e. ambulance)			
16b. Narrative Description: (1) Describe any medical treatment received as a result of the accident; (2) Provide additional information about the boxes checked in 16a. above; and (3) Provide other related information. You may continue the Narrative Description on back of form.			
17a. Name of Person Completing Part II		17b. Highway User's Representative's Name (if applicable):	18. Signature
Check Appropriate Box: <input type="checkbox"/> Highway User <input type="checkbox"/> Highway User's Representative		Telephone Number:	
		Relationship:	
			19. Date

Note: Railroads are required to send this form under 49 CFR 225.

FORM FRA F 6180.150 (Rev. 08/10) NOTE THAT RAILROAD MUST REPORT ALL REPORTABLE CASUALTIES ON FORM FRA F 6180.55a

DRAFT

OMB approval expires 02/28/2011

**HIGHWAY USER INJURY INQUIRY FORM
(Continued)**

Identifying Information (from first page) :		
Date of Accident/Incident (mm/dd/yyyy)	Railroad Accident/Incident Number	
Highway User's Last Name	First Name	Middle Initial

Narrative Description - Continued (If additional space was needed in the Narrative Description boxes (15b. and 16b.), from the other side of this form, please continue the narrative in this box.)

OMB Paperwork Reduction Statement (Forms)

Public reporting burden for this information collection is estimated to average 95 minutes per response - 50 minutes for railroads to complete their portion of the form and 45 minutes for highway users to complete their portion of the form. This estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. According to the Paperwork Reduction Act of 1995, a federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with, a collection of information unless it displays a currently valid OMB control number. The valid OMB control number for this information collection is 2130-0500. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to: Information Collection Officer, Federal Railroad Administration, 1200 New Jersey Ave., S.E., Washington D.C. 20590.