



ACCIDENT INFORMATION REQUIRED FOR POST-ACCIDENT TOXICOLOGICAL TESTING (49 CFR PART 219)

NOTE: This form must be completed by the Railroad Representative present at the collection facility.

1. Name of Railroad or Regulated Service Contractor	2. Name(s) of Other Railroads or Regulated Service Contractors		
3. Date of Accident (month/day/year)	4. Time of Accident <div style="text-align: right;"> : <input type="checkbox"/> AM <input type="checkbox"/> PM </div>		
5. Location of Accident (City and State)	6. FRA Tox Box Number		
7. Event which Qualifies Accident for Mandatory Post-Accident Testing (one must be checked) NOTE: All accident events (not incidents) must meet the railroad property damage reporting threshold.			
MAJOR TRAIN ACCIDENT: ___ Fatality ___ \$1,500,000 damage or more (to railroad property) ___ Release of hazardous material (and evacuation) ___ Release of hazardous material (and reportable injury from product)			
IMPACT ACCIDENT: ___ Reportable injury ___ Damage of \$150,000 or more (to railroad property)			
PASSENGER TRAIN ACCIDENT: ___ Reportable injury to any person in the accident			
TRAIN INCIDENT: ___ Fatality to on-duty railroad employee			
HUMAN-FACTOR HIGHWAY-RAIL GRADE CROSSING ACCIDENT/INCIDENT: ___ Regulated employee failed to provide for safety of highway traffic before interfering with highway-rail grade crossing signal system. ___ Train crewmember failed to flag highway traffic after highway-rail grade crossing signal system failure. ___ Regulated employee who is or who should have been performing the duties of an appropriately equipped flagger failed to flag highway traffic after highway-rail grade crossing signal system failure. ___ Fatality of any on-duty regulated employee. ___ Regulated employee violated FRA regulation or railroad operating rule which may have contributed to accident cause or severity.			
8. Name and Address of Collection Facility	9. Telephone Number of Collection Facility () () ()		
10. Employee(s) Whose Samples are Contained in this Shipping Box. NOTE: A sample set identification number is pre-printed on FRA Form 6180.74 and differs for each person.			
NAME OF EMPLOYEE	JOB TITLE (engineer, conductor, etc.)	TRAIN ID/ON TRACK EQUIPMENT	SAMPLE SET IDENTIFICATION NUMBER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
11. Name of Medical Review Officer	12. Address of Medical Review Officer Telephone: () () ()		
13. Name of Railroad Representative	14. Address of Railroad Representative Telephone: () () ()		
15. Signature of Railroad Representative	16. Date (month/day/year)	17. Was a breath alcohol test conducted pursuant to the above accident under FRA Authority? If yes, include ATF in box.	
_____	_____	___ YES ___ NO	

Public reporting burden for this information collection is estimated to average 15 minutes per response, including 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 **2130-0526**. 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., N.W., Washington D.C. 20590.



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