HIGHWAY USER INJURY INQUIRY FORM

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration (FRA)

OMB 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 ☐ AM ☐ 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? ☐ Yes ☐ 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.):

☐ (i) Receive medical treatment beyond first aid (i.e. prescription medication or stitches)
☐ (ii) Lose consciousness
☐ (iii) Suffer a fractured or cracked bone, or a punctured eardrum diagnosed by a physician or other licensed health care provider
☐ (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 Check Appropriate Box: ☐ Highway User ☐ Highway User's Representative	17b. Highway User's Representative's Name (if applicable): Telephone Number: Relationship:	18. Signature	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

OMB approved 6/6/2018, Approval expires 6/30/2021

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.)