

## HIGHWAY USER INJURY INQUIRY FORM

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration (FRA)

**OMB No. 2130-0500**

<b>PART I – Highway Rail-Grade Crossing Accident/Incident (To be completed by reporting railroad)</b>			
1a. Date of Accident/Incident (mm/dd/yyyy)	1b. Time of Accident/Incident <span style="float: right;"><input type="checkbox"/> AM <input type="checkbox"/> PM</span>		
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.
<b>PART II - Highway User Statement (To be completed by highway user or highway user's representative)</b>			
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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
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  Check Appropriate Box:  <input type="checkbox"/> Highway User <input type="checkbox"/> 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.)

**Public reporting burden is estimated to average 50 minutes per response for railroads for their part of this form and 45 minutes for highway users or their representatives for their part of this form. This includes the time for reviewing instructions, searching existing databases, gathering and maintaining the data needed, and completing and reviewing the collection of information. Responses by the railroad are mandatory and responses by highway users or their representatives to this collection of information are voluntary. The information collected is a matter of public record, and no confidentiality is promised to any respondent. Please note that an agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The OMB control number for this collection is 2130-0500.**