CSX TRANSPORTATION

EMPLOYEE'S INJURY AND/OR ILLNESS REPORT

FORM PI-1A

INSTRUCTIONS FOR FORM PI-1A

1. This report will be completed by the employee as soon as possible after an injury/illness. If the employee is unable to complete this form, it may be typed or written by another employee; the employee must initial each answer entered in this manner.
2. Completed Form PI-1A will be furnished to the employee's supervisor who, after review of the report and seeing that it is complete and signed, will fax and then mail the original to the reporting office in Jacksonville.
3. Supervisor will furnish the claims representative, in whose area of responsibility the accident/incident occurred, a copy of this report.

INCIDENT NUMBER (Leave blank)	EMPLOYEE NAME	ID NUMBER
01 R _ _ _ _ _ _ _ _ _	02	03

ADDRESS ( )

04 (Street Address) (City) (State) (Zip Code) (Phone No.)

DATE OF BIRTH Mo. / Day / Yr.	AGE	OCCUPATION	DEPARTMENT	SUPERVISOR
05	06	07	08	09

DATE HIRED Mo. / Day / Yr.	NUMBER CONSECUTIVE DAYS WORKED	NUMBER OF HOURS OFF PRIOR TO TOUR OF DUTY
10	11	12

INCIDENT LOCATION	INCIDENT CITY	INCIDENT COUNTY	INCIDENT STATE
13 (Shop, Plant, Track, Station, Train, Etc.)	14	15	16

MILEPOST (To Nearest Tenth)	DIVISION	INCIDENT DATE Mo. / Day / Yr.	INCIDENT TIME	VISIBILITY
17	18	19	20 ☐ AM ☐ PM	21 ☐ Dawn ☐ Dusk ☐ Daylight ☐ Dark

WEATHER
22 ☐ Clear ☐ Rain ☐ Sleet ☐ Cloudy ☐ Fog ☐ Snow

NATURE OF COMPLAINT
23

WAS MEDICAL ATTENTION PROVIDED?
24 ☐ Yes ☐ No If Yes, Name and Address of Physician and Medical Facility.

DESCRIBE MEDICAL/FIRST-AID TREATMENT RECEIVED
25

WAS PRESCRIPTION MEDICATION INCLUDED IN TREATMENT?
☐ Yes ☐ No

DESCRIBE THE INCIDENT
26

IS THIS A RECURRENCE?
27 ☐ Yes ☐ No

WILL INCIDENT RESULT IN LOST WORKDAYS?
28 ☐ Yes ☐ No Number of Days

WAS ANYONE AT FAULT?
29 ☐ Yes ☐ No If Yes, Who and to What Extent?

DID DEFECTIVE TOOL OR EQUIPMENT CAUSE INCIDENT?
30 ☐ Yes ☐ No If Yes, Describe and Specify Defect.

Revision D. Effective April 2008

ADDITIONAL SPACE FOR REPORT INFORMATION

DID EMPLOYEE HAVE A SAFE PLACE IN WHICH TO WORK?

31 ☐ Yes ☐ No If No, Specify the Safety Hazard.

WAS THE WORKPLACE ADEQUATELY LIGHTED?

32 ☐ Yes ☐ No If No, Describe Conditions.

WAS THERE ANY FAILURE TO GIVE USUAL OR NECESSARY SIGNALS, WARNINGS OR PROTECTION?	IF ON-TRACK EQUIPMENT WAS INVOLVED, GIVE INITIALS AND NUMBERS.
33 ☐ Yes ☐ No	34

LOCATION WHERE EMPLOYEE NORMALLY REPORTS.

NAME OF FACILITY _____

35 STREET	CITY	STATE	ZIP

NAMES AND ADDRESSES OF WITNESSES TO THE INCIDENT

36

EMPLOYEE SIGNATURE	WITNESS TO EMPLOYEE SIGNATURE
37	38
DATE	NAME OF SUPERVISOR NOTIFIED
39	40

MEDICAL INFORMATION RELEASE

I hereby authorize the release of all medical information reports and other medical data by any doctor, hospital, examiner or other healthcare provider relative to the injury/injuries sustained in this accident to the Chief Medical Officer and any other appropriate officer or representative of CSX TRANSPORTATION. A photocopy of this authorization is as valid as the original.

SPECIFY TYPE OF INSURANCE COVERAGE IDENTIFIED ON YOUR INSURANCE CARD

SIGNATURE OF EMPLOYEE DATE