Employee Report of Incident, Injury, or Illness on CN U.S. Properties ("ERI")

Rev. 9/18/2017

Instructions: Employees must use this form to report work-related injuries, occupational illnesses, or significant incidents, including incidents that could have caused serious injuries. The reporting employee must complete this form and give it to their supervisor on the incident date. If the employee cannot complete the form, the supervisor should contact Risk Mitigation. Completed forms should be distributed as instructed in the current timetable, with all original papers given to the Risk Mitigation Officer.

REPORTING EMPLOYEE INFORMATION		
I am reporting: ☐ an incident ☐ an injury ☐ an occupational illness **(Check all that apply)**		
Your name:	PIN:	Date of birth:
Home address:	Best phone number to reach you:	
Job title/occupation:	Supervisor:	
Work days & times:	Rest days:	

INCIDENT			
Date:	Time:	Exact place of occurrence:	Time you came on duty:
What were you doing when the incident occurred?			
Describe how the incident occurred, including the events and circumstances that you think led up to the incident (continue on back if necessary):			
Do you think defective tools or equipment contributed to the incident? ☐ yes ☐ no If *yes*, describe the suspected defect:			
Provide ID number(s) of any railcar, locomotive, train, machinery, or equipment directly involved in the incident: Remote Control operation? ☐ Yes ☐ no Were you operating remote? ☐ yes ☐ no			
Names and job titles of your crew members:			
Names and job titles of everyone who witnessed the incident or can provide any information about it:			

INJURY (If applicable)		
Which parts of your body were injured?		Diagnosis or type of injury:
Did you seek medical treatment for this injury? ☐ yes ☐ no	If *yes*, date and time you first saw a medical practitioner for this injury: ______________________	
Treating Medical Practitioner's Information		
Name:	Address:	Phone number: _____ - _____- ________

OCCUPATIONAL ILLNESS (If applicable)	
Diagnosis (*i.e.,* name of medical condition or illness):	Date of initial diagnosis:
Describe your symptoms (continue on back if necessary):	Date you first noticed symptoms:

Diagnosing Medical Practitioner's Information		
Name:	Address:	Phone number:______-_____-__________

Reporting Employee Signature: ____ Date: ______________________________

For Management Use Only:

Received By:____Title:_________________________________ Date:_____________________