NORFOLK SOUTHERN

FORM 11131 (Rev. 5/04) Item # (162646)

REPORT OF EMPLOYEE PERSONAL INJURY ILLNESS/INCIDENT

MENU IS THIS RELATED TO A REPORTABLE TRAIN OR CROSSING ACCIDENT? NO_____ CROSSING_____ TRAIN_____ (Over Rptng Threshold)

EMPLOYEE EIN_____RELATED TO REPORT NO._____

EMPLOYEE NAME_____ _____ _____(Name Computer Generated by EIN onto Screen 1 – but enter first name)
(FIRST) (MIDDLE) (LAST)

SCREEN 1 – LOCATION AND EMPLOYEE

INCIDENT NUMBER_____(Computer Generated)

INCIDENT DATE ____/____/____/ TIME: ____: ____AM___PM____

COMPANY *_____ DEPARTMENT* _____

DIVISION * _____ FACILITY* _____ CHRG TO*_____

LOCATION * (Select One:) LINE OF ROAD_____TERMINAL_____SHOP OR OFFICE BUILDING_____OFF RAILROAD PROPERTY_____MILEPOST_____

INCIDENT CITY_____ COUNTY_____ STATE _____ZIP_____

WEATHER * (Select One:) CLEAR ____ CLOUDY ____ RAIN ____ FOG ____ SLEET ____ SNOW ____ DOES NOT APPLY ____ (Injury Occurred Indoors)

VISIBILITY * (Select One:) DAWN ____ DAY ____ DUSK ____ DARK ____ INDOORS-DARK ____ INDOORS-DIM ____ INDOORS-NORMAL ____ INDOORS-OTHER ____

TEMPERATURE: _____ PLUS_____ MINUS_____ GENDER: Male _____ Female _____

HEIGHT: _____FT. _____IN. WEIGHT: _____LBS. EMPLOYEE RIN NUMBER _____ JOB * _____

REST DAYS * (Select All That Apply:) MONDAY ____ TUESDAY ____ WEDNESDAY ____ THURSDAY ____ FRIDAY ____ SATURDAY ____ SUNDAY ____ NONE ____

ASSIGNMENT: REGULAR _____ RELIEF _____ EXTRA _____ MONTHS IN AREA OR ON ASSIGNMENT _____

ON DUTY? YES _____ NO _____ EXPOSURE TO HAZMAT? YES _____ NO _____ ON COMPANY PROPERTY? YES _____ NO _____

HOURS ON DUTY AT TIME OF INCIDENT _____ REST HOURS PRIOR TO THIS TOUR OF DUTY _____

AT COMPANY-SPONSORED EVENT OR IN COMPANY PROVIDED TRANSPORTATION: YES _____ NO _____

EMPLOYEE NOTIFIED COMPANY: DATE ____/____/____ PERSON NOTIFIED: _____ TIME: ____:____AM___PM___

SUPERIVSOR'S EIN: _____ NAME _____(Computer Generated by EIN)

SCREEN 2 - INJURY AND TREATMENT

ACCIDENT TYPE * _____ BODY PART * _____

INJURY TYPE * _____ ACTIVITY * _____

OBJECT OF ACTIVITY * _____ SOURCE OF INJURY * _____

SAFETY ATTIRE WORN * (Select All That Apply:) HARD HAT _____ EYE _____ HEARING _____ RESPIRATORY _____ FOOT _____ HAND _____ OTHER ____ NONE ____

NAME BRAND OF EYE PROTECTION WORN: * _____

WAS ANY TYPE OF EQUIPMENT INVOLVED? _____ (Y or N) STATIONARY _____ MOVING _____

EQUIPMENT TYPE * (Select One:) FRIEGHT ____ PASSENGER ____ MIXED ____ WORK ____ YARD/SWITCHING ____ LIGHT LOCO ____ M/W EQUIPMENT ____ NONE ____

INIT. AND NUMBER: _____ SHOP _____ OTHER _____

WAS EQUIPMENT DEFECTIVE? _____ (Y or N) IF YES, HOW _____

TYPE OF MEDICAL ATTENTION * (Select One:) DECLINED TREATMENT ____ FIRST AID ____ PRESCRIPTION (FRA Reportable) ____ MEDICAL TREATMENT (FRA Reportable) ____

DESCRIBE TREATMENT RENDERED: _____

PROVIDER _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

DISABILITY: NONE _____ RESTRICTED ACTIVITY _____ LOST TIME _____ PERMANENT _____

RESTRICTED ACTIVITY: BEGIN DATE ____/____/____ END DATE ____/____/____ DAYS _____ ACT _____ EST _____

LOST TIME: BEGIN DATE ____/____/____ END DATE ____/____/____ DAYS _____ ACT _____ EST _____

PERMANENT: DEATH _____ TERMINATED _____ TRANSFER _____ EFFECTIVE DATE ____/____/____

SCREEN 2A – CIRCUMSTANCE CODES (Entries Will Be Selected By Department Based Upon Content Of This Form)

---------- FORCE ACCOUNT SECTION ----------

IS THIS INJURY ASSOCIATED WITH FORCE ACCOUNT WORK? _____ (Y or N)

(WORK PERFORMED FOR 3RD PARTIES WHERE THE COST OF THE WORK IS REIMBURSED)

SCREEN 3 - INCIDENT DESCRIPTIONS

EMPLOYEE'S DESCRIPTION OF INCIDENT: _____

SUPERVISOR'S DESCRIPTION OF INCIDENT: _____

SCREEN 3A – SPECIAL CAPTURE CODES / COVERED DATA:

____ PRESCRIBED TIME OFF, BUT NO DAYS WERE ACTUALLY TAKEN (TYPE A)

____ PRESCRIBED RESTRICTION OF ROUTINE WORK DUTIES, (TYPE R)
BUT RESTRICTION DID NOT OCCUR

____ PRESCRIBED OTC MEDICATION AT PRESCRIPTION STRENGTH, (TYPE P)
OR SINGLE EXTERNAL APPLICATION OF PRESCRIPTION MEDICATION

NOTE: CHECK ALL THAT APPLY – TYPE PRECEDENCE = (TYPE A < TYPE R < TYPE P)

LONGITUDE (OPITONAL)

__ ____ DEGREES (066 – 098) _____ DECIMAL (000000 – 999999)

LATITUDE (OPITONAL)

__ ____ DEGREES (024– 049) _____ DECIMAL (000000 – 999999)

SCREEN 4 – TESTING AND WITNESSES

TYPE OF DRUG TESTS ADMINISTERED NONE ____ BLOOD ____ URINE ____ BOTH ____

TYPE OF ALCOHOL TESTS ADMINISTERED NONE ____ BLOOD ____ BREATH ____ BOTH ____

WITNESSES (If Employee: ENTER ONLY NAME, EIN AND TELEPHONE NUMBER)

NAME _____ EIN _____ TELEPHONE ____ - ____ - ____

ADDRESS _____ CITY _____ ST _____ ZIP _____

NAME _____ EIN _____ TELEPHONE ____ - ____ - ____

ADDRESS _____ CITY _____ ST _____ ZIP _____

NAME _____ EIN _____ TELEPHONE ____ - ____ - ____

ADDRESS _____ CITY _____ ST _____ ZIP _____

Copies of Injury Report will be automatically sent to Safety, Casualty Claims – Norfolk and Medical Departments.

(ENTER MESSAGE SWITCHING ADDRESSES FOR DISTRICT CLAIM AGENT, LOCAL CLAIM AGENT, AND APPROPRIATE SUPERVISORS OR SEVEN-CHARACTER TCAM PRINTER ID:)

1 _____ MSG ADDR _____ 2 _____ MSG ADDR _____

3 _____ MSG ADDR _____ 4 _____ MSG ADDR _____

5 _____ MSG ADDR _____ 6 _____ MSG ADDR _____

SCREEN 5 – SUMMARY

WORKSHEET COMPLETED BY _____ TITLE _____ DATE ____/____/____

* Asterisk indicates that entry corresponds with selection table in computer. Six computer screens must be completed to transmit. Computer access – 1) Thoroughbred Screen: Select R (IDMS), type in user ID & password; OR; Netview Access Screen: Type in user ID, password, & Group (UCRGRP); select application IDMS. 2) type the word INJURY at ENTER NEXT TASK CODE, select MENU option. Help screens available in computer program.

COMPLETE ALL ITEMS