NORFOLK SOUTHERN

FORM 22 (REV. 5/04) ITEM # (162612)

PERSONAL INJURY REPORT

REPORT DATE:_____ DEPARTMENT

REPORT TIME (_____AM) or (_____PM) _____ DIVISION

TRAIN NO. *(If applicable)* _____ Is this incident related to a Train or Crossing Accident? [ ] Yes [ ] No

TO: Supervisory Officer: _____ FROM: Injured Employee: _____ Employee ID No. _____

INCIDENT DATE: _____ INCIDENT TIME: (_____ AM) or (_____ PM)

LOCATION: Select one: Line of Road _____ Terminal _____ Shop or Office Building _____ Off Railroad Property _____

INCIDENT CITY: _____ STATE: _____ MILEPOST: *(If applicable)* _____

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) or (_____ MINUS)

HEIGHT: _____ FT. _____ IN. WEIGHT _____ LBS. OCCUPATION _____

REST DAYS: *Select all that apply:* Monday ____ Tuesday ____ Wednesday ____ Thursday ____ Friday ____ Saturday ____ Sunday ____ None ____

ASSIGNMENT: REGULAR _____ RELIEF _____ EXTRA _____

ON DUTY: [ ] Yes [ ] No HOURS ON DUTY AT TIME OF INCIDENT _____

SAFETY ATTIRE WORN: *Select all that apply:* Head ____ Eye ____ Hearing ____ Respiratory ____ Foot ____ Hand ____ Other ____ None ____

WAS ANY TYPE OF EQUIPMENT INVOLVED? [ ] Yes [ ] No STATIONARY _____ MOVING _____

EQUIPMENT TYPE: Select One: Freight ___ Passenger ___ Mixed ___ Work ___ Yard Switching ___ Light Locos ___ M/W Equipment ___None ___

INITIAL AND NUMBER: _____

WITNESS NAMES	ADDRESSES
_____	_____
_____	_____
_____	_____

DO YOU DESIRE MEDICAL ATTENTION AT THIS TIME? [ ] Yes [ ] No

DESCRIBE WHAT HAPPENED – GIVE SPECIFIC, DETAILED INFORMATION: _____

_____

_____

_____

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_____

SIGNATURE OF EMPLOYEE

Distribution: Original to Supervisory Officer
Photocopy to Injured