

NS Lincoln Accident

# Injury Forms

**226A117**  
**Engineer**  
**A. Smith Jr.**

**PERSONAL INJURY REPORT**

REPORT DATE: 1/18/06 DEPARTMENT TRAFFIC  
REPORT TIME ( 8:09 AM) or ( PM) DIVISION ALABAMA

TRAIN NO. (If applicable) 226A1 Is this incident related to a Train or Crossing Accident?  Yes [ ] No

TO: Supervisory Officer: SE Smith FROM: Injured Employee: A - Smith Employee ID No. 0806939

INCIDENT DATE: 1/18/06 INCIDENT TIME: ( 4:00 AM) or ( PM)

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

INCIDENT CITY: Coosa STATE: AL MILEPOST: (If applicable) 758.0

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: (60 PLUS) or ( \_\_\_\_\_ MINUS)

HEIGHT: 5 FT. 8 IN. WEIGHT 190 LBS. OCCUPATION ENGINEER

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 2 HR 45 MIN

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 Locomotives \_\_\_\_\_ M/W Equipment \_\_\_\_\_ None \_\_\_\_\_

TRAIN AND NUMBER: DOES NOT REMEMBER

WITNESS NAMES	ADDRESSES
<u>M. M. QUINN</u>	_____
<u>B. MAGABURN</u>	_____

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

DESCRIBE WHAT HAPPENED - GIVE SPECIFIC, DETAILED INFORMATION:  
HAD clear signal at Riverside came around curve at Coosa, the other train was in the siding <sup>when</sup> and we were level on top of it.

[Signature]  
SIGNATURE OF EMPLOYEE / 505 Filled out Foron. A Smith signed

Distribution: Original to Supervisory Officer  
Photocopy to Injured

**REPORT OF EMPLOYEE PERSONAL INJURY ILLNESS/INCIDENT**

MENU IS THIS RELATED TO A REPORTABLE TRAIN OR CROSSING ACCIDENT? NO  CROSSING  TRAIN  (Over Rptng Threshold)

LOYEE EIN 0806939 RELATED TO REPORT NO. \_\_\_\_\_

EMPLOYEE NAME A SMITH JR. (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 1/18/06 TIME: 4:17 AM PM

COMPANY \* NORFOLK SOUTHERN RAILROAD DEPARTMENT \* TRANSPORTATION

DIVISION \* ALABAMA DIVISION FACILITY \* N/A CHRG TO \* S.E. SMITH

LOCATION \* (Select One:) LINE OF ROAD  TERMINAL \_\_\_\_\_ SHOP OR OFFICE BUILDING \_\_\_\_\_ OFF RAILROAD PROPERTY \_\_\_\_\_ MILEPOST 258.0

INCIDENT CITY LINCOLN COUNTY TALLADEGA STATE AL ZIP 35160

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: 61 PLUS  MINUS \_\_\_\_\_ GENDER: Male  Female \_\_\_\_\_

HEIGHT: 5 FT. 8 IN. WEIGHT: 190 LBS. EMPLOYEE RIN NUMBER 21530 JOB \* 226A117

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

ASSIGNMENT: REGULAR  RELIEF \_\_\_\_\_ EXTRA \_\_\_\_\_ MONTHS IN AREA OR ON ASSIGNMENT LESS THAN (1) MONTH Assignment

ON DUTY? YES  NO \_\_\_\_\_ EXPOSURE TO HAZMAT? YES \_\_\_\_\_ NO  ON COMPANY PROPERTY? YES  NO \_\_\_\_\_

HOURS ON DUTY AT TIME OF INCIDENT 3HR. 2min REST HOURS PRIOR TO THIS TOUR OF DUTY 2187HR. 37mi.

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

EMPLOYEE NOTIFIED COMPANY: DATE 1/18/06 PERSON NOTIFIED: S.E. SMITH TIME: 8:09 AM PM

SUPERVISOR'S EIN: 0060012 NAME S.E. SMITH (Computer Generated by EIN)

**SCREEN 2 - INJURY AND TREATMENT**

ACCIDENT TYPE \* COLLISION RAIL EQUIPMENT BODY PART \* HEAD, CHEST, RIGHT LEG

INJURY TYPE \* BRUISE, CONTUSION ACTIVITY \* OPERATING

OBJECT OF ACTIVITY \* RAIL EQUIPMENT (TRAIN) SOURCE OF INJURY \* RAIL EQUIPMENT (LOCOMOTIVE)

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

NAME BRAND OF EYE PROTECTION WORN: \* UVEEX

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 \_\_\_\_\_

INT. AND NUMBER: NS 7137 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: X-RAYS, GAS TESTS, STITCHES, CT SCAN

PROVIDER CITIZENS BAPTIST MEDICAL CENTER

ADDRESS 604 STONE AVENUE CITY TALLADEGA ST AL ZIP 35160

DISABILITY: NONE \_\_\_\_\_ RESTRICTED ACTIVITY \_\_\_\_\_ LOST TIME  PERMANENT \_\_\_\_\_

RESTRICTED ACTIVITY: BEGIN DATE \_\_\_\_\_ END DATE \_\_\_\_\_ DAYS \_\_\_\_\_ ACT \_\_\_\_\_ EST \_\_\_\_\_

LOST TIME: BEGIN DATE 1/18/06 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 3<sup>RD</sup> PARTIES WHERE THE COST OF THE WORK IS REIMBURSED)

SCREEN 3 - INCIDENT DESCRIPTIONS

EMPLOYEE'S DESCRIPTION OF INCIDENT:

HAD clear signal at Riverside, came around curve at Coosa; the other train was in the siding in the clear, we were lined in on top of it.

REPORTER'S DESCRIPTION OF INCIDENT:

Employee was crew member of TRAIN 226A117 that impacted rear end of TRAIN 226A116. Cause under investigation

SCREEN 3A - SPECIAL CAPTURE CODES / COVERED DATA:

- PRESCRIBED TIME OFF, BUT NO DAYS WERE ACTUALLY TAKEN (TYPE A)
  - PRESCRIBED RESTRICTION OF ROUTINE WORK DUTIES, BUT RESTRICTION DID NOT OCCUR (TYPE R)
  - PRESCRIBED OTC MEDICATION AT PRESCRIPTION STRENGTH, OR SINGLE EXTERNAL APPLICATION OF PRESCRIPTION MEDICATION (TYPE P)
- NOTE: CHECK ALL THAT APPLY - TYPE PRECEDENCE = (TYPE A < TYPE R < TYPE P)

LONGITUDE (OPTIONAL)

DEGREES (066 - 098) DECIMAL (000000 - 999999)

LATITUDE (OPTIONAL)

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 B. M. MASHBURN EIN 0143640 TELEPHONE [REDACTED]  
ADDRESS CITY ST ZIP

NAME M. M. QUINN EIN 0148730 TELEPHONE [REDACTED]  
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

J. E. Smith

TITLE

TRAINMASTER

DATE

1/19/06

\* 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.

\* A Smith SIDE 2

COMPLETE ALL ITEMS

**226A117**  
**Conductor**  
**M. M. Quinn**

**PERSONAL INJURY REPORT**

REPORT DATE: 1/18/06 DEPARTMENT: Transportation  
REPORT TIME: ( ) AM or ( 8:16 ) PM DIVISION: ACABAMA

TRAIN NO. (If applicable) 226A1 Is this incident related to a Train or Crossing Accident?  Yes [ ] No

TO: Supervisory Officer: S.E. Smith FROM: Injured Employee: M.M. Quinn Employee ID No. 0148730

INCIDENT DATE: 1/18/06 INCIDENT TIME: ( ) AM or ( 4:00 ) PM

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

INCIDENT CITY: COOSA STATE: AL MILEPOST: (If applicable) 758.0

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: ( 52 PLUS ) or ( \_\_\_\_\_ MINUS )

HEIGHT: 6 FT. 1 IN. WEIGHT 225 LBS. OCCUPATION Conductor

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 2 HRS 45 MIN

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 Locus \_\_\_\_\_ M/W Equipment \_\_\_\_\_ None \_\_\_\_\_

VEHICLE MAKE AND NUMBER: 7137 BUT NOT SURE

WITNESS NAMES: A Smith ADDRESSES: \_\_\_\_\_  
B MASHBURN \_\_\_\_\_

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

DESCRIBE WHAT HAPPENED - GIVE SPECIFIC, DETAILED INFORMATION: Left Pell City on A-1  
Applied signal following train 22R, got to Riverside  
Signal and signal was clear, proceeded on  
to COOSA came around curve and observed  
signal clear and was level for the  
siding. Engineer placed the train in  
emergency and own train struck rear of  
TRAIN 22R

SIGNATURE OF EMPLOYEE: \_\_\_\_\_ / get filled out. signed by M.M. Quinn

Distribution: Original to Supervisory Officer  
Photocopy to Injured

**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 0148730 RELATED TO REPORT NO. \_\_\_\_\_  
EMPLOYEE NAME M. M. QUINN (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 1/18/06 TIME: 4:17 AM  PM   
COMPANY \* NORFOLK SOUTHERN RR DEPARTMENT \* TRANSPORTATION  
DIVISION \* ALABAMA FACILITY \* N/A CHRG TO \* S.E. SMITH  
LOCATION \* (Select One): LINE OF ROAD  TERMINAL \_\_\_\_\_ SHOP OR OFFICE BUILDING \_\_\_\_\_ OFF RAILROAD PROPERTY \_\_\_\_\_ MILEPOST \_\_\_\_\_  
INCIDENT CITY WINCON COUNTY TALLADEGA STATE AL ZIP 35160  
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: 61 PLUS  MINUS \_\_\_\_\_ GENDER: Male  Female \_\_\_\_\_  
HEIGHT: 6 FT. 1 IN. WEIGHT: 225 LBS. EMPLOYEE RIN NUMBER 21530 JOB \* 226A117  
REST DAYS \* (Select All That Apply): MONDAY \_\_\_\_\_ TUESDAY \_\_\_\_\_ WEDNESDAY \_\_\_\_\_ THURSDAY \_\_\_\_\_ FRIDAY \_\_\_\_\_ SATURDAY \_\_\_\_\_ SUNDAY \_\_\_\_\_ NONE   
ASSIGNMENT: REGULAR \_\_\_\_\_ RELIEF \_\_\_\_\_ EXTRA  MONTHS IN AREA OR ON ASSIGNMENT 3  
ON DUTY? YES  NO  EXPOSURE TO HAZMAT? YES \_\_\_\_\_ NO  ON COMPANY PROPERTY? YES  NO   
HOURS ON DUTY AT TIME OF INCIDENT 3HR 2MIN REST HOURS PRIOR TO THIS TOUR OF DUTY 28HRS 10MIN  
AT COMPANY-SPONSORED EVENT OR IN COMPANY PROVIDED TRANSPORTATION: YES \_\_\_\_\_ NO   
EMPLOYEE NOTIFIED COMPANY: DATE 1/18/06 PERSON NOTIFIED: S.E. SMITH TIME: 8:10 AM  PM   
SUPERVISOR'S EIN: 0060012 NAME S.E. SMITH (Computer Generated by EIN)

**SCREEN 2 - INJURY AND TREATMENT**

ACCIDENT TYPE \* COLLISION RAIL EQUIPMENT BODY PART \* RIGHT SHOULDER  
INJURY TYPE \* Bruise, Contusion ACTIVITY \* RIDING  
OBJECT OF ACTIVITY \* RAIL EQUIPMENT (TRAIN) SOURCE OF INJURY \* RAIL EQUIPMENT (LOCOMOTIVE)  
SAFETY ATTIRE WORN \* (Select All That Apply): HARD HAT \_\_\_\_\_ EYE  HEARING  RESPIRATORY \_\_\_\_\_ FOOT  HAND \_\_\_\_\_ OTHER \_\_\_\_\_ NONE \_\_\_\_\_  
NAME BRAND OF EYE PROTECTION WORN: \* UVEX  
WAS ANY TYPE OF EQUIPMENT INVOLVED?  (Y or N) STATIONARY \_\_\_\_\_ MOVING   
EQUIPMENT TYPE \* (Select One): FRIEGHT  PASSENGER \_\_\_\_\_ MIXED \_\_\_\_\_ WORK \_\_\_\_\_ YARD/SWITCHING \_\_\_\_\_ LIGHT LOCO \_\_\_\_\_ MW EQUIPMENT \_\_\_\_\_ NONE \_\_\_\_\_  
INIT. AND NUMBER: NS 7137 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: CT SCAN X RAYS, GASTROSES  
PROVIDER CITIZEN BAPTIST MEDICAL CENTER  
ADDRESS 604 STONE AVENUE CITY TALLADEGA ST AL ZIP 35160  
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 3<sup>RD</sup> PARTIES WHERE THE COST OF THE WORK IS REIMBURSED)



SCREEN 3 - INCIDENT DESCRIPTIONS

EMPLOYEE'S DESCRIPTION OF INCIDENT: Left Fall City on an Approach Signal following TRAM 22R, got to Riverside signal and signal was clear, proceeded on to Coast Curve. Came around curve and observed signal clear and struck REAR OF TRAM 22R.  
SUPERVISOR'S DESCRIPTION OF INCIDENT: Employee was crew member of TrAM 226A17 that impacted rear of TRAM 22R116. CAUSE UNDER INVESTIGATION

SCREEN 3A - SPECIAL CAPTURE CODES / COVERED DATA:

PRESCRIBED TIME OFF, BUT NO DAYS WERE ACTUALLY TAKEN (TYPE A)  
PRESCRIBED RESTRICTION OF ROUTINE WORK DUTIES, BUT RESTRICTION DID NOT OCCUR (TYPE R)  
PRESCRIBED OTC MEDICATION AT PRESCRIPTION STRENGTH, OR SINGLE EXTERNAL APPLICATION OF PRESCRIPTION MEDICATION (TYPE P)  
NOTE: CHECK ALL THAT APPLY - TYPE PRECEDENCE = (TYPE A < TYPE R < TYPE P)

LONGITUDE (OPTIONAL)

DEGREES (066 - 096) DECIMAL (000000 - 999999)

LATITUDE (OPTIONAL)

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 A SMITH JR EIN 0806939 TELEPHONE [REDACTED]  
ADDRESS CITY ST ZIP

NAME B. M. MASHBURN EIN 0163640 TELEPHONE [REDACTED]  
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 J. E. Smith TITLE TRAINMASTER DATE 1/19/00

\* 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.

\* M. M. QUINN SIDE 2  
COMPLETE ALL ITEMS

**226A117**  
**ACT**  
**B. M. Mashburn**

**PERSONAL INJURY REPORT**

REPORT DATE: 1/18/06 DEPARTMENT \_\_\_\_\_

START TIME ( 8:30 PM ) or ( 8:30 PM ) Alabama, Birmingham DIVISION

TRAIN NO. (If applicable) 226 ALL Is this incident related to a Train or Crossing Accident?  Yes [ ] No

TO: Supervisory Officer: S.E. Smith FROM: Injured Employee: Blake Mashburn Employee ID No. 0163640

INCIDENT DATE: 1/18/06 INCIDENT TIME: ( \_\_\_\_\_ AM ) or ( 4:00 PM )

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

INCIDENT CITY: Coosa STATE: AL MILEPOST: (If applicable) 758.0

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: ( 60 PLUS ) or ( \_\_\_\_\_ MINUS )

HEIGHT: 5 FT. 0 IN. WEIGHT 150 LBS. OCCUPATION ACT

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 1 1/2 - 2 hrs

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 \_\_\_\_\_

VEHICLE IDENTIFICATION NUMBER: BMM

WITNESS NAMES: A. Smith \_\_\_\_\_ ADDRESSES: \_\_\_\_\_

WITNESS NAMES: M.M. Quinn \_\_\_\_\_ ADDRESSES: \_\_\_\_\_

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

DESCRIBE WHAT HAPPENED - GIVE SPECIFIC, DETAILED INFORMATION: We came up on a clear signal & proceeded around the curve where we noticed we were lined in on top of another train in the siding

\_\_\_\_\_  
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\_\_\_\_\_

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\_\_\_\_\_

[Signature]  
SIGNATURE OF EMPLOYEE

Distribution: Original to Supervisory Officer  
Photocopy to Injured

**REPORT OF EMPLOYEE PERSONAL INJURY ILLNESS/INCIDENT**

MENU IS THIS RELATED TO A REPORTABLE TRAIN OR CROSSING ACCIDENT? NO CROSSING TRAIN  (Over Rptng Threshold)

LOYEE EIN 0163640 RELATED TO REPORT NO. \_\_\_\_\_

EMPLOYEE NAME B. M. MASHBURN (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 1/18/06 TIME: 4:17 AM PM

COMPANY \* NORFOLK SOUTHERN RAILROAD DEPARTMENT \* TRANSPORTATION

DIVISION \* ALABAMA FACILITY \* N/A CHRG TO \* S.E. SMITH

LOCATION \* (Select One): LINE OF ROAD  TERMINAL \_\_\_\_\_ SHOP OR OFFICE BUILDING \_\_\_\_\_ OFF RAILROAD PROPERTY \_\_\_\_\_ MILEPOST 758.0

INCIDENT CITY LINCOLN COUNTY TALLADEGA STATE AL ZIP 35160

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: 61 PLUS  MINUS \_\_\_\_\_ GENDER: Male  Female \_\_\_\_\_

HEIGHT: 5 FT. 8 IN. WEIGHT: 150 LBS. EMPLOYEE RIN NUMBER 21530 JOB \* 226A117

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

ASSIGNMENT: REGULAR  RELIEF \_\_\_\_\_ EXTRA \_\_\_\_\_ MONTHS IN AREA OR ON ASSIGNMENT LESS THAN (1) MONTH

ON DUTY? YES  NO \_\_\_\_\_ EXPOSURE TO HAZMAT? YES \_\_\_\_\_ NO  ON COMPANY PROPERTY? YES  NO \_\_\_\_\_

HOURS ON DUTY AT TIME OF INCIDENT 3 HR. 2 MIN. REST HOURS PRIOR TO THIS TOUR OF DUTY 27 HR 20 MIN

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

EMPLOYEE NOTIFIED COMPANY: DATE 1/18/06 PERSON NOTIFIED: S.E. SMITH TIME: 8:30 AM PM

SUPERVISOR'S EIN: 0060012 NAME S.E. SMITH (Computer Generated by EIN)

**SCREEN 2 - INJURY AND TREATMENT**

ACCIDENT TYPE \* COLLISION RAIL EQUIPMENT BODY PART \* RIGHT ANKLE, BACK

INJURY TYPE \* BRUISE, CONTUSION ACTIVITY \* RIDING

OBJECT OF ACTIVITY \* RAIL EQUIPMENT (TRAIN) SOURCE OF INJURY \* RAIL EQUIPMENT (LOCOMOTIVE)

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

NAME BRAND OF EYE PROTECTION WORN: \* UVEEX

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

EQUIPMENT TYPE \* (Select One): FRIEGHT  PASSENGER \_\_\_\_\_ MIXED \_\_\_\_\_ WORK \_\_\_\_\_ YARD/SWITCHING \_\_\_\_\_ LIGHT LOCO \_\_\_\_\_ MW EQUIPMENT \_\_\_\_\_ NONE \_\_\_\_\_

INIT. AND NUMBER: NS 7137 SHOP \_\_\_\_\_ OTHER \_\_\_\_\_

WAS EQUIPMENT DEFECTIVE? N (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: SPLINT RIGHT FOOT

PROVIDER CITIZEN BAPTIST MEDICAL CENTER

ADDRESS 604 STONE AVENUE CITY TALLADEGA ST AL ZIP 35160

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? N (Y or N)

(WORK PERFORMED FOR 3<sup>RD</sup> PARTIES WHERE THE COST OF THE WORK IS REIMBURSED)