



SC# 4805943529-1
FORM PI-1A RPM
REV. 2/99

EMPLOYEE'S INCIDENT REPORT

HIGHWAY USER INVOLVED

1. This report will be completed by the employee as soon as possible after an accident/incident. 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 RPM 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 01 <input type="text"/>			EMPLOYEE NAME 02 <input type="text"/>			ID NUMBER 03 <input type="text"/>		SOCIAL SECURITY NO. 04 <input type="text"/>	
ADDRESS 05 (Street Address) (City) (State) (Zip Code) (Phone No.)									
DATE OF BIRTH 06 Mo. Day Yr.			AGE 07	OCCUPATION 08		DEPARTMENT 09		SUPERVISOR 10	
DATE HIRED 11 Mo. Day Yr.			NUMBER CONSECUTIVE DAYS WORKED 12 <input type="text"/>			NUMBER OF HOURS OFF PRIOR TO TOUR OF DUTY 12a <input type="text"/>			
INCIDENT LOCATION 13 (Shop, Plant, Track, Station, Train, Etc.)				INCIDENT CITY 14		INCIDENT COUNTY 15		INCIDENT STATE 16	
MILEPOST (To Nearest Tenth) 17			DIVISION 18		INCIDENT DATE 19 Mo. Day Yr.		INCIDENT TIME 20 <input type="checkbox"/> AM <input type="checkbox"/> PM		VISIBILITY 21 <input type="checkbox"/> Dawn <input type="checkbox"/> Daylight <input type="checkbox"/> Dusk <input type="checkbox"/> Dark
WEATHER 22 <input type="checkbox"/> Clear <input type="checkbox"/> Rain <input type="checkbox"/> Sleet <input checked="" type="checkbox"/> Cloudy <input type="checkbox"/> Fog <input type="checkbox"/> Snow			NATURE OF COMPLAINT 23 <input type="text"/>						
WAS MEDICAL ATTENTION PROVIDED? 24 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>If Yes, Name and Address of Physician and Medical Facility.</i>									
DESCRIBE MEDICAL/FIRST-AID TREATMENT RECEIVED 25 <input type="text"/>					WAS PRESCRIPTION MEDICATION INCLUDED IN TREATMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
DESCRIBE THE INCIDENT 26 <input type="text"/>									
27 IS THIS A RECURRENCE? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
WILL INCIDENT RESULT IN LOST WORKDAYS? 28 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No No. of Days <input type="text"/>					WAS ANYONE AT FAULT? 29 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>If Yes, Who and to What Extent?</i>				
DID DEFECTIVE TOOL OR EQUIPMENT CAUSE INCIDENT? 30 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>If Yes, Describe and Specify Defect.</i>									



