THE KANSAS CITY SOUTHERN RAILWAY COMPANY / GATEWAY EASTERN RAILWAY

68-E EMPLOYEE REPORT OF INJURY AND ILLNESS

Revised 10/12

All cases of personal injury, while on duty or on company property, must be immediately reported to the responding manager and the prescribed form(s) completed. All cases of occupational illness must be immediately reported to the proper manager and the prescribed form(s) completed. If employee is unable to complete the report, another person may transcribe exactly the employee's wording. It must be noted on the form that it was completed at the employee's request, and the employee's signature must be secured on form by the responding manager. Supervisor must fill out a Manager's Report of Employee Injury or Illness and ***fax reports to the Regulatory Reporting Office at 816-218-0123, within 24 hours of the incident.*** *Mail originals to Kansas City Southern, Regulatory Reporting Office, P.O. Box 219335, Kansas City, MO 64121-9335.*

1. FULL NAME OF INJURED EMPLOYEE: *(First, MI, Last)*	2. DATE HIRED:	3. EMPLOYEE ID NO.:
4. ADDRESS OF INJURED EMPLOYEE: (Street, City, State, Zip)		5. HOME PHONE NO.:
6. OCCUPATION:	7. DEPARTMENT	8. SEX: ☐ M ☐ F / 9. DATE OF BIRTH:
10. ADDRESS WHERE EMPLOYEE NORMALLY REPORTS FOR DUTY (Street, City, State, Zip):		
11. DATE OF INJURY *(MM/DD/YY/YY)*:	12. TIME OF INJURY:	13. TIME SHIFT BEGAN:
14. SCHEDULED REST DAYS: (Mark all that apply) ☐ Su ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ None	15. FUTURE VACATION DAYS SCHEDULED PRIOR TO THIS INJURY:	
16. LOCATION WHERE INJURY OCCURRED: (Street, Track, Building, etc.)		
17. NEAREST MILEPOST: (If applicable) ☐ Main Track ☐ Yard	18. CITY:	19. COUNTY/PARISH: / 20. STATE & ZIP:
21. WEATHER CONDITIONS: ☐ Clear ☐ Rain ☐ Sleet ☐ Other (Explain) ☐ Cloudy ☐ Snow ☐ Fog	22. VISIBILITY: ☐ Daylight ☐ Dawn ☐ Artificial Lighting ☐ Dark ☐ Dusk	
23. WHAT JOB OR ACTIVITY WAS BEING PERFORMED AT TIME OF INJURY:		
24. DESCRIBE INJURY/ILLNESS AND ALL BODY PARTS AFFECTED:		
5. HOW DID INJURY OCCUR? (Include a sequence of events leading up to injury) (Use separate sheet if necessary):		
26. LIST INITIAL AND NUMBER OF ANY CARS, LOCOMOTIVES OR EQUIPMENT INVOLVED:		
27. DID YOU COME IN DIRECT CONTACT WITH A LEAD OR SPILL OF HAZARDOUS MATERIAL, CHEMICAL OR SUBSTANCE?: ☐ Yes ☐ No IF YES, LIST HAZARDOUS MATERIAL, CHEMICAL OR SUBSTANCE:		
28. WERE YOU EXAMINED BY A DOCTOR? ☐ Yes ☐ No DOCTOR'S NAME:	DOCTOR'S ADDRESS:	
29. LIST CREW OR GANG MEMBERS (Use separate sheet if necessary):		
30. LIST WITNESSES (Name, Address & Phone) (Use separate sheet if necessary):		
31. WAS 65-E HIGHWAY-RAIL GRADE CROSSING REPORT COMPLETED? ☐ Yes ☐ No	32. WAS A 66-E RAIL EQUIPMENT ACCIDENT REPORT COMPLETED? ☐ Yes ☐ No	
33. NAME OF EMPLOYEE COMPLETING REPORT:		
34. DATE AND TIME THAT YOU FIRST NOTIFIED COMPANY OF THIS INCIDENT: Date: Time:	35. WHO DID YOU NOTIFY OF THIS INCIDENT?:	
36. FULL NAME AND SIGNATURE OF INJURED EMPLOYEE (Print and Sign to Complete Submission)		37. DATE REPORT COMPLETED:
Supervisor - Fax to the Regulatory Reporting Office within 24 hours of incident: 816-218-0123		