U.S. Department of Transportation
Federal Railroad Administration

ACCIDENT INFORMATION REQUIRED FOR POST-ACCIDENT TOXICOLOGICAL TESTING (49 CFR PART 219)

NOTE: This form must be completed by the Railroad Representative present at the collection facility.

1. Name of Reporting Railroad	2. Name(s) of Other Railroads Involved in Accident
3. Date of Accident (month /day/year)	4. Time of Accident ____ : ____ Hr Min ☐ AM ☐ PM
5. Locations of Accident (City and State)	6. Nearest Railroad Station

7. Event which Qualifies Accident for Mandatory Post-Accident Testing (one must be checked)

NOTE: All accident events (not incidents) must meet the railroad property damage reporting threshold.

MAJOR TRAIN ACCIDENT:
- ___ Fatality
- ___ $1,000,000 damage or more (to railroad property)
- ___ Release of hazardous material (and evacuation)
- ___ Release of hazardous material (and reportable injury from product)

IMPACT ACCIDENT:
- ___ Reportable injury
- ___ Damage of $150,000 or more (to railroad property)

PASSENGER TRAIN ACCIDENT:
- ___ Reportable injury to any person in the accident

TRAIN INCIDENT:
- ___ Fatality to on-duty railroad employee

8. Name and Address of Collection Facility	9. Telephone Number of Collection Facility ( )

10. Employee(s) Whose Samples are Contained in this Shipping Box.

NOTE: A sample set identification number is pre-printed on FRA Form 6180.74 and differs for each person.

NAME OF EMPLOYEE	JOB TITLE (engineer, conductor, etc.)	TRAIN DESIGNATION	SAMPLE SET IDENTIFICATION NUMBER

11. Name of Medical Review Officer	12. Address of Medical Review Officer Telephone: ( )
13. Name of Railroad Representative	14. Address of Railroad Representative Telephone: ( )

15. Signature of Railroad Representative	16. Date (month/day/year)	17. Was a breath alcohol test conducted pursuant to the above accident under FRA Authority? ___ Yes ___ No

FRA 6180.73 (Revised 10/94)

OMB No. 2130-0526

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FRA