

UNION PACIFIC RAILROAD REPORT OF PERSONAL INJURY OR OCCUPATIONAL ILLNESS

FORM 52032
Rev. 11/07

RULE 12.5, UNION PACIFIC RAILROAD OPERATING RULES STATES: All cases of personal injury, while on duty or on company property, must be immediately reported to the proper manager and the prescribed form completed. A personal injury that occurs while off duty that will in any way affect employee performance of duties must be reported to the proper manager as soon as possible. An injured employee must also complete the prescribed written form before returning to service. All cases of occupational illness must be immediately reported to the proper manager and the prescribed form completed. Both the railroad and employees are required by Federal regulations to report injuries and occupational illnesses that meet certain medical treatment criteria; employees must report to their manager any medical treatment they receive that was directly related to their injury or illness, including any follow-up visits. Below are examples of the types of medical treatments and instructions that employees must report to their manager if they were given in relation to an injury or occupational illness: Medical treatments provided or recommended; Physical therapy or chiropractic treatments; Prescriptions and other medications issued or recommended, including dosages; Lost time instructions; Work restriction instructions.

INSTRUCTIONS: Answer all questions in each applicable section in your own handwriting as soon as possible after an accident/incident occurs if injured, either on or off duty or if you are reporting a work-related illness. (If unable to complete the report, necessary information must be furnished by the person doing so in the employee's behalf.)

SECTION I - IDENTIFICATION INFORMATION

(1) YOUR NAME (First, Middle, Last)	(2) YOUR HOME ADDRESS	(3) CITY	(4) ST	(5) ZIP CODE
(6) YOUR OCCUPATION ON DAY OF INJURY	(7) YOUR HOME PHONE ()	(8) YOUR AGE	(9) HIRE DATE	
(10) YOUR EMPLOYEE ID NUMBER	(11) YOUR SUPERVISORS NAME	(12) ASSIGNED REST DAYS		

SECTION II - DETAILS OF ACCIDENT/INJURY

(1) DATE OF INJURY	(2) TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	(3) WHERE WERE YOU INJURED (NEAREST CITY, STATE, RR LOCATION, ETC.)?	(4) TIME SHIFT OR TRIP BEGAN
(5) MILE POST: SUB DIVISION:	<input type="checkbox"/> MAIN/TRACK <input type="checkbox"/> YARD	(6) WEATHER: <input type="checkbox"/> CLEAR <input type="checkbox"/> RAIN <input type="checkbox"/> CLOUDY <input type="checkbox"/> SLEET TEMPERATURE ____ ° <input type="checkbox"/> SNOW <input type="checkbox"/> FOG <input type="checkbox"/> OTHER	(7) VISIBILITY: <input type="checkbox"/> DAYLIGHT <input type="checkbox"/> DARK <input type="checkbox"/> DAWN <input type="checkbox"/> ARTIFICIAL LIGHTING <input type="checkbox"/> DUSK
(8) WERE YOU INJURED: <input type="checkbox"/> ON DUTY <input type="checkbox"/> ON COMPANY PROPERTY <input type="checkbox"/> OFF DUTY <input type="checkbox"/> OFF COMPANY PROPERTY			
(9) SPECIFIC JOB OR ACTIVITY BEING PERFORMED AT TIME OF ACCIDENT/INJURY: _____			

SECTION III - DETAILS OF ACCIDENT/INJURY OR OCCUPATIONAL ILLNESS

(1) DESCRIBE FULLY HOW THE ACCIDENT/INJURY OCCURRED:

(2) WHAT SPECIFICALLY CAUSED THE ACCIDENT/INJURY:

(3) DID EQUIPMENT OR TOOLS CAUSE OR CONTRIBUTE TO THE CAUSE OF THE ACCIDENT/INJURY? YES NO IF YES, PROVIDE DETAILS (INCLUDING EQUIPMENT ID NUMBER)

(4) DID WORKING CONDITIONS CAUSE OR CONTRIBUTE TO THE CAUSE OF THE ACCIDENT/INJURY? YES NO IF YES, PROVIDE COMPLETE DETAILS

(5) DID OTHER PERSONS CAUSE OR CONTRIBUTE TO THE CAUSE OF THE ACCIDENT/INJURY? YES NO IF YES, PROVIDE COMPLETE DETAILS

(6) NAMES, OCCUPATIONS AND ADDRESSES OF ALL CREW MEMBERS AND/OR OTHER PERSONS WHO WITNESSED OR HAVE ANY KNOWLEDGE OF ACCIDENT/INCIDENT:

SECTION IV - IF OCCUPATIONAL ILLNESS - PROVIDE ADDITIONAL DETAILS

(1) WHAT IS YOUR ILLNESS OR CONDITION?

(2) WHEN DID YOU FIRST BECOME AWARE THAT THIS CONDITION MAY HAVE BEEN CAUSED BY YOUR WORK? HOW DID YOU LEARN THIS?

(3) LIST ANY JOB(S), EXPOSURE(S), OR LOCATION(S) THAT YOU BELIEVE MAY HAVE CAUSED OR CONTRIBUTED TO YOUR SYMPTOMS (PLEASE PROVIDE DATES):

(4) DO YOU HAVE ANY CURRENT EXPOSURES? IF SO, PLEASE EXPLAIN:

SECTION V - NATURE OF INJURY/OCCUPATIONAL ILLNESS AND TREATMENT

(1) DESCRIBE INJURY OR ILLNESS:

(2) WHAT ARE YOUR SYMPTOMS?

(3) WHEN DID YOU FIRST NOTICE SYMPTOMS? (GIVE DATE)

(4) WHEN WERE YOU FIRST TREATED OR DIAGNOSED?

(5) PARTS OF BODY AFFECTED

SIDE OF BODY RIGHT LEFT BOTH

(6) WERE YOU EXAMINED BY A MEDICAL PROFESSIONAL? YES NO IF YES, GIVE MEDICAL PROFESSIONAL'S NAME AND ADDRESS:

(7) TREATMENT REQUIRED: NONE FIRST AID TREATED & RELEASED X-RAYS HOSPITALIZED OTHER (Explain):

IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL

(8) WHAT TREATMENT WAS GIVEN?

(9) MEDICATION INSTRUCTIONS

WAS A PRESCRIPTION WRITTEN? YES NO IF YES: MEDICATION _____ DOSAGE _____

IF NO PRESCRIPTIONS WERE WRITTEN, WERE OTHER MEDICATIONS ISSUED OR RECOMMENDED?

YES NO IF YES: MEDICATION _____ DOSAGE _____

(10) INDICATE YOUR CURRENT HEALTH CARE COVERAGE PLAN: UPREHS UHC OTHER LIST:

SECTION VI - EQUIPMENT INVOLVED IN ACCIDENT/INJURY (IF APPLICABLE)

(1) TRAIN SYMBOL (2) ENGINE NUMBER (3) CONSIST (Loads, Emples, Tons) (4) IDENTIFYING INITIALS & NUMBERS OF EQUIPMENT INVOLVED IN ACCIDENT/INCIDENT

(5) WAS EQUIPMENT ON MAINTRACK YARD TIMETABLE DIRECTION _____ (6) WERE THERE ANY DEFECTS IN THE EQUIPMENT? YES NO

(7) IF THE ANSWER TO QUESTION 6 IS YES, STATE THE NATURE OF THE DEFECTS, IDENTIFY THE DEFECTIVE EQUIPMENT, AND COMPLETE (8).

(8) WERE THE DEFECTIVE CONDITIONS MARKED? YES NO (9) DID THIS ACCIDENT/INCIDENT RESULT FROM RIDING ON BOARDING OR ALIGHTING FROM, OR BEING STRUCK OR RUN OVER BY MOVING EQUIPMENT? YES NO

(10) COMMENTS:

I certify that the foregoing information is true and correct.

(Signature of Employee)

(Signature of Witness)

(Date Completed)

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(Printed Name of Witness)