EMPLOYEE PERSONAL INJURY/OCCUPATIONAL ILLNESS REPORT

Each employee incurring an injury or occupational illiness on duty and/or on property must fill out this section and forward entire form to their supervisor.

NAME OF INJURED PERSON	AGE	DATE OF BIRTH	SENIORITY DATE	SOCIAL SECURITY NUMBER

ADDRESS OF INJURED PERSON (STREET, CITY, ZIP CODE)	TELEPHONE NUMBER
	( )

LOCATION OF INJURY (CITY AND STATE)	MILE POST	STATION NO.	DATE OF INJURY	TIME
				☐ AM ☐ PM

If Occupational Illness (Repetitive trauma, carpal tunnel, hearing loss, etc.)

WHEN DID YOU FIRST NOTICE SYMPTOMS?		WHEN WERE YOU FIRST TREATED?
TEMPERATURE (Degrees)	VISIBILITY (Check correct response) ☐ DAWN ☐ DUSK ☐ DAY ☐ DARK	WEATHER (Check correct response) ☐ CLEAR ☐ RAIN ☐ SLEET ☐ CLOUD ☐ FOG ☐ SNOW

DESCRIBE FULLY HOW INJURY OR OCCUPATIONAL ILLNESS OCCURRED:

DESCRIBE INJURIES OR OCCUPATIONAL ILLNESS:

Was the accident caused by the conduct of any person other than yourself? ☐ yes ☐ no If yes, please describe:

Could you, by more care on your part, have prevented your injury? ☐ yes ☐ no If yes, how?

TYPE OF MEDICAL ATTENTION ADMINISTERED (PRESCRIPTION, BRACE, SPLINT, ETC):

NAME OF ATTENDING PHYSICIAN: ADDRESS:

NAME OF ATTENDING FACILITY: ADDRESS:

IF INJURY OCCURRED WHILE WORKING WITH ON TRACK EQUIPMENT, LIST INITIALS AND NUMBERS:

DEFFECTS INVOLVED: ☐ NONE ☐ MACHINERY ☐ STRUCTURES ☐ EQUIPMENT ☐ OTHER DEFECTS

IF ANY DEFECTS INVOLVED, IDENTIFY AND DESCRIBE:

Have you ever sustained an injury before? ☐ yes ☐ no If yes, please state date, place and part of body injured:

IMPORTANT: List All Persons Who Witnessed the Injury or Can Give Any Information About It:

NAME	OCCUPATION	ADDRESS (Show Street and City)

THE ABOVE IS A CORRECT STATEMENT

Signed ______________________ Date __________ BNSF Employee Number __________

ANSWER ALL QUESTIONS FULLY (Use Reverse Side If Necessary)

NOTE: IF EMPLOYEE IS UNABLE TO COMPLETE THIS FORM, SUPERVISOR MUST COMPLETE AND HAVE EMPLOYEE SIGN.