

# UNION PACIFIC RAILROAD REPORT OF PERSONAL INJURY OR OCCUPATIONAL ILLNESS

FORM 52032  
Rev. 01/04

**RULE 1.2.5. 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. The injured employee must also complete the prescribed written form before returning to service. If an employee receives a medical diagnosis of occupational illness, he or she must report it immediately to the proper manager. If an employee is injured on-duty he must report to his manager any follow-up visits to any doctor or other medical care provider resulting from the injury. Specifically, the injured employee must report all physical therapy or chiropractic treatments, prescriptions issued, work restrictions and medical treatments."

**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 SOCIAL SECURITY NUMBER	(11) YOUR EMPLOYEE ID NUMBER	(12) YOUR SUPERVISORS NAME			(13) 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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PROVIDE DETAILS (INCLUDING EQUIPMENT ID NUMBER)  _____
(4) DID WORKING CONDITIONS CAUSE OR CONTRIBUTE TO THE CAUSE OF THE ACCIDENT/INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PROVIDE COMPLETE DETAILS  _____
(5) DID OTHER PERSONS CAUSE OR CONTRIBUTE TO THE CAUSE OF THE ACCIDENT/INJURY? <input type="checkbox"/> YES <input type="checkbox"/> 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, Empties, 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) 20 \_\_\_\_\_

\_\_\_\_\_  
(Printed Name of Witness)