UNION PACIFIC RAILROAD
REPORT OF PERSONAL INJURY OR OCCUPATIONAL ILLNESS

FORM 52032
Rev. 07/19

GENERAL CODE OF OPERATING RULES (GCOR) Rule 1.2.5: Reporting. All cases of personal injury, while on duty or on company property, must be accurately, timely, and immediately reported to the proper manager. For injuries that result in medical evaluation and/or treatment from an outside provider, employees must complete the prescribed form. 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 form before returning to service. Because railroads are required by Federal Regulations to report injuries and occupational illnesses that meet certain medical treatment criteria, when medical treatment is received from an outside provider, employees must report to their manager medical treatment they receive that is directly related to their injury or illness, including follow-up visits.

Below are examples of the types of medical treatments and instructions that employees must report to their manager, if provided in relation to an injury or occupational illness: Medical treatment provided or recommended; Physical therapy or chiropractic treatments; Prescriptions and other medications issued or recommended, including dosages; Lost work day instructions; Work restriction instructions.

INSTRUCTIONS: *Answer all questions in each applicable section in your own handwriting. 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 ☐ AM ☐ PM	(3) WHERE WERE YOU INJURED (NEAREST CITY, STATE, RR LOCATION, ETC.)?	(4) TIME SHIFT OR TRIP BEGAN
(5) MILE POST: ☐ MAIN/TRACK SUB DIVISION: ☐ YARD		(6) WEATHER: ☐ CLEAR ☐ RAIN ☐ CLOUDY ☐ SLEET TEMPERATURE _____° ☐ SNOW ☐ FOG ☐ OTHER	(7) VISIBILITY: ☐ DAYLIGHT ☐ DARK ☐ DAWN ☐ ARTIFICIAL LIGHTING ☐ DUSK

(8) WERE YOU INJURED? (check all that apply): ☐ ON DUTY ☐ ON COMPANY PROPERTY ☐ INJURY OCCURRED OVER A PERIOD OF TIME
☐ OFF DUTY ☐ OFF COMPANY PROPERTY ☐ INJURY OCCURRED AS A RESULT OF A SPECIFIC INCIDENT(S)

(9) SPECIFIC JOB OR ACTIVITY BEING PERFORMED AT TIME OF ACCIDENT/INJURY/ILLNESS:

SECTION III - SUMMARY OF ACCIDENT/INJURY/OR OCCUPATIONAL ILLNESS

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

(2) WHAT SPECIFICALLY CAUSED THE ACCIDENT/INJURY/ILLNESS:

(3) WHAT MEDICAL CONDITION DID THE ACCIDENT/INJURY/ILLNESS CAUSE:

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

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

(6) DID WORKING CONDITIONS CAUSE OR CONTRIBUTE TO THE CAUSE OF THE ACCIDENT/INJURY/ILLNESS? ☐ YES ☐ NO
IF YES, LIST ANY JOB(S), EXPOSURE(S), OR LOCATION(S) THAT YOU BELIEVE MAY HAVE CAUSED OR CONTRIBUTED TO YOUR SYMPTOMS (INCLUDE DATES):

(7) DID OTHER PERSONS CAUSE OR CONTRIBUTE TO THE CAUSE OF THE ACCIDENT/INJURY/ILLNESS? ☐ YES ☐ NO
IF YES, PROVIDE COMPLETE DETAILS TO INCLUDE NAMES OF THE PERSON(S) THAT CAUSED OR CONTRIBUTED TO THE ACCIDENT/INJURY/ILLNESS

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

SECTION IV - NATURE OF INJURY/OCCUPATIONAL ILLNESS AND TREATMENT

(1) DESCRIBE INJURY OR ILLNESS:

(2) PARTS OF BODY AFFECTED SIDE OF BODY ☐ RIGHT ☐ LEFT ☐ BOTH

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

(4) WHAT ARE YOUR SYMPTOMS?

(5) WHEN WERE YOU FIRST TREATED OR DIAGNOSED?

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

(7) WHAT TREATMENT WAS PROVIDED: ☐ NONE ☐ FIRST AID ☐ TREATED & RELEASED ☐ X-RAYS ☐ HOSPITALIZED ☐ OTHER (Explain):

IF TREATMENT WAS PROVIDED, PLEASE PROVIDE DETAILS INCLUDING NAME OF TREATING PHYSICIAN AND FACILITY.

(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 V - 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:

Federal law and accident reporting regulations require Union Pacific Railroad to submit certain accident and injury information to the Federal Railroad Administration. 49 U.S.C. § 20901 & 49 CFR Part 225. Information provided in this form will be used by Union Pacific Railroad in its accident reporting submissions to the Federal Railroad Administration. Therefore, you must provide truthful and accurate information on this form that is consistent with your best recollection of the events surrounding your injury. By signing below, you affirm that the information provided in this form is true, accurate, and represents your own recollection of the events.

____
(Signature of Employee)

____
(Signature of Witness)
Company Representative

____
(Date Completed)

____
(Printed Name of Witness)
Company Representative

Employee
If you received any assistance filling out this form, please state who assisted and why:

Manager
If you assisted the employee in filling out this form, please state why and sign below:

Signature:________________