

# EMPLOYEE PERSONAL INJURY/OCCUPATIONAL ILLNESS REPORT

supervisor (pursual	nt to § 228.19). A copy will b	e provided upon n	quest	n property must fill out	this report and provide it to his or her		
NAME OF TILIURED PERSON		AGE	AGE DATE OF BIRTH		EMPLOYEE ID NUMBER		
ADDRESS OF INJURED PI	ERSON (STREET, CITY, ZIP CODE)	<del></del>	-		TELEPHONE NUMBER		
				iii	( )		
LOCATION OF INJURY (CITY AND STATE)		MILE POST SUBDIVISION (IF APPLICABLE) (IF APPLICABLE)		DATE OF INJURY	□AM □FM		
TEMPERATURE	VISIRILITY (Check correct response)	DAY	DUSK Casck com	eet CAR	RASN SLEET/ICE		
IF 7185 IS AN ILL NESS OF NOTICE SYMPTOMS?	CONDITION RATHER THAN AN ACL	TE MJURY, WHEN DE	YOU FIRST	E YOU FIRST TREATED OR DI	AGNOSED?		
DESCRIBE INJURIES OR I	LLNESS/IXXXIXITON: punich advisored	pages 8					
DESCRIBE FULLY HOW R	HUMY, ILLNESS OR CONDITION OC	CURRED: (vituals mitritions	i pagna if osceptacy)				
WAS THE ACCIDENT CAU	SED BY THE CONDUCT OF ANOTHE	R PERSON?	IF YES, PLE	ASE DESCRIBE:			
Yes	Mo						
COULD YOU HAVE PREVE	ENTED YOUR JUJURY?		IF YES, WE				
WAS THERE ANY DEFECT PROCEDURES? Yes	TMALFUNCTION PROBLEM OF ANTH	THE EQUIPMENT OR W	ORK #YES, PLE	ASE DESCRIBE:			
TYPE OF MEDICAL ATTE	ITION ADMINISTERED (PRESCRIPTIO	CN, BRACE, SPLINT, ETC	<b>3):</b>				
NAME OF PHYSICIAN:		J	ADDRESS:				
NAME OF ATTENDING FAC	CHLTY:		ADDRESS:				
SUPERVISOR NAME:	supervisor:  If you experi If you are an before visiti	ience any complication while to perform your ng a health care profe	one resulting from your normal duties or abser assional for subsequen	Injuryfiliness.	ne, you must promptly notify your far seeignment because of this injury@ness. due to your injury.		
	BLE WORKING WITH ON TRACK EQ						
IMPORTANT: LIST ALL PERSONS WHO WITNESSED THE INJURY O				ADDRESS (Show Street and City)			
NAME		OCCUPATION			ALLONCESS (Show Street and City)		
					MINI S. OTT. CONTES WITH		
Signed					Date		

PLEASE ANSWER ALL QUESTIONS (USE REVERSE SIDE IF NECESSARY)

- Describe injuries or illness/condition:
  - Hurt back

- Describe fully how injury or occupational illness occurred
  - Bad Order Switch



# EMPLOYEE PERSONAL INJURY/OCCUPATIONAL ILLNESS REPORT

				operty must fill out	this report and provide it to his or her	
SUPERVISOR (pursuant to § 225.19). A copy will b		e provided upon re	DATE OF BIRTH	SENIORITY DATE	EMPLOYEE ID NUKSER	
			1		1	
ADDRESS OF INJURED PE	RESON (STREET, CITY, ZIP CODE)				TELEPHONE NUMBER	
LOCATION OF INJURY (CITY AND STATE)		MILE POST (IF APPLICABLE)	SUBDIVISION (IF APPLICABLE)	DATE OF PAURY	TIME.	
TEMPERATURE	(Check correct response)	DAWN [	DUSK (Chack correct response)	CLEAR CLOUDY	RAIN DESTICE	
IF THE IS AN ILLNESS OR MOTICE SYMPTOMS?	CONDITION RATHER THAN AN ACL	ITE MJURY, WHEN DID Y	QU FIRST WHEN WERE YO	U FIRST TREATED OR DIA	JUNOS	
DESCRIBE INJURIES OF II	LLNESS/CONDITION: princh anythinal	naces of management				
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	JURY, ILLNESS OR CONDITION OC		Darlin & successivi)			
WAS THE ACCIDENT CAU	SED BY THE CONDUCT OF ANOTHE	R PERSON?	IF YES, PLEASE	DESCRIBE:		
COULD YOU HAVE PREVE	NTED YOUR JILIURY?	•	IF YES, HOW?			
	HALFUNCTION PROBLEM OF MITH	THE EQUIPMENT OR WO	F YES, PLEASE	OFFICE OF STREET		
PROCEDURES?	☐ No		P TOS. PCDOSC	and a second sec		
TYPE OF MEDICAL ATTEN	TION ADMINISTRICED (PRESCRIPTIO	OM, BRACE, SPLINT, ETC				
NAME OF PHYSICIAN:	- Co CHAI 1		ADDRESS:			
HAME OF ATTENDANG FAC	алу:		ADDRESS:			
SUPERVISOR NAME:	supervisor:  If you experi	ence eny complication	ne resulting from your inju	ry/illness. urself from your regula	re analgament because of this injuryBiness.	
IF BLURY COCURRED VOI	ILE WORDING WITH ON TRACK EQ					
IMPORTANT: LIST ALL PE	ersona who withe65ed the mu	Commence of the Commence of the				
MAKE OCCUPATI		CCUPATION		ADDRESS (Show Street and City)		
Signed				744	Date	

• Was the accident caused by the conduct another person?

□ <u>YES!</u>

 Could you by more care on your part have prevented the injury.

□NO

PLEASE ANSWER ALL QUESTIONS (USE REVERSE SIDE IF NECESSARY)



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	ting an injury, condition of to § 225.19). A copy will b			y and/or on pro	perty must fill out	this report	and provide it to his or her
NAME OF INJURED PERSON		AGE	E DATE OF BIRTH		SENIORITY DATE	EMPLOYEE ID NUMBER	
ADDRESS OF INJURED PE	SON (STREET, CITY, ZIP CODE)	L				-	TELEPHONE NUMBER
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LOCATION OF INJURY (CITY AND STATE)		MILE POST SUBONISIO			DATE OF INJURY		TIME
		(II. Whiteverse)				AMPM	
TEMPERATURE	(Check correct response)	DAWN [	DUSK	WEATHER (Check correct response)	CLEAR	RAIN	SLEET/ICE
		DAY	DARK		CLOUDY	F00	sucw
IF THIS IS AN ILLNESS OR I NOTICE SYMPTOMS?	CONDITION RATHER THAN AN AC	UTE MJURY, WHEN DID Y	OU HRST	WHEN WERE YOU	FIRST TREATED OR D	VAGNOSED?	
DESCRIBE NUURIES ON IL	LNESS/CONDITION: proch actions	pages if necassery)				9	
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DESCRIBE FILLY NOW BUT	URY, ILL HEES OR CONDITION OC	CURRENT DESAR SERVICE	There & Page 14	1001			
Description of the second	ONI, ILLIAND ON GOILDMAN GO	SUIVED: HEAR BEILING	-	and i			
WAS THE ACCIDENT CALLS	ED BY THE CONOUCT OF ANOTHE	D DESCUNS		IF YES, PLEAS	PSCRIBE-		
You	☐ No	A LINE OF THE OWNER OWNER OF THE OWNER OWNE			*)		6
COULD YOU HAVE PREVEN	TED YOUR INJURY?			ES, HOW?			
Yes	No			É.,	1000		
WAS THERE ANY DEFECTS PROCEDURES?	MALFUNCTION PROBLEM OF AVAIT	THE EQUIPMENT ON W		F YES, PLEASE	ESCRINE:		
T ven	∏ Nn						
	L						
TYPE OF MEDICAL ATTEM	TON AUMINISTIERED (PRESCRIPTI	on, Brace, Splint, etc	*				
NAME OF PHYSICIAN:	· ·			ADDRESS:			
NAME OF ATTENDING FAC	LITY:		-	ADDRESS:			
SUPERVISOR NAME:	NOTE - If you do not rec	alva marfaul trashmen	t as the re	a with and otherine fundament	or occupations? illus	Unit nous	arrowally actific unit
	If you exper     If you exper     If you are ur	lence any complication	ns resulting normal dut	g from your injur	yfillness. meil from your regu	lar seeignme	nt because of this injuryfilines
F INJURY COCURRED VAN	LE WORKING WITH ON TRACK EQ	ng a treath care profe UIPMENT, LIST INITIALS	AND NUMBE	eubsequent trea R8:	tment or observation	sue to your	injury.
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IMPORTANT: LIST ALL PERSONS WHO WITNESSED THE INJ NAME		OCCUPATION			7	ADDRESS (St.	ow Street and City)
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Signed		<del></del>					Data
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Was there any defect malfunction problems of or with the equipment or work procedures?

YESB/O Switch

# **BNSF 72 HOUR RULE**

■ If the employee experiences muscular aches and pains from "routine" work that do not appear to be serious when they first occur, he or she has 72 hours to notify the appropriate supervisor that an injury has occurred. Employees will not be disciplined for "late reporting" of this type of injury as long as they:

# **BNSF 72 HOUR RULE**

- 1. Report the injury within 72 hours of the probable triggering event;
- 2. Notify the supervisor before seeking medical attention; and
- 3. The medical attention verifies that the injury was most likely linked to the event specified.