BNSF EMPLOYEE REPORT OF PERSONAL INJURY/ILLNESS SAF 51662

SUBMIT ORIGINAL SIGNED AND DATED FORM TO BNSF CLAIMS REPRESENTATIVE

ELECTRONICALLY SCANNED COPY TO:

safety.incidentreporting@bnsf.com

BNSF RAILWAY

EMPLOYEE PERSONAL INJURY/OCCUPATIONAL ILLNESS REPORT

Each employee reporting an injury, condition or occupational illness on duty and/or on property must fill out this report and provide it to his or her supervisor (pursuant to § 225.19). A copy will be provided upon request.

NAME OF INJURED PERSON	AGE	DATE OF BIRTH	SENIORITY DATE	EMPLOYEE ID NUMBER

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

LOCATION OF INJURY (CITY AND STATE)	MILE POST (IF APPLICABLE)	SUBDIVISION (IF APPLICABLE)	DATE OF INJURY	TIME
				☐ AM ☐ PM

TEMPERATURE	VISIBILITY (Check correct response)			WEATHER (Check correct response)			
	☐ DAWN	☐ DUSK		☐ CLEAR	☐ RAIN	☐ SLEET/ ICE	
	☐ DAY	☐ DARK		☐ CLOUDY	☐ FOG	☐ SNOW	

IF THIS IS AN ILLNESS OR CONDITION RATHER THAN AN ACUTE INJURY, WHEN DID YOU FIRST NOTICE SYMPTOMS?	WHEN WERE YOU FIRST TREATED OR DIAGNOSED?

DESCRIBE INJURIES OR ILLNESS/CONDITION: (attach additional pages if necessary)

DESCRIBE FULLY HOW INJURY, ILLNESS OR CONDITION OCCURRED: (attach additional pages if necessary)

WAS THE ACCIDENT CAUSED BY THE CONDUCT OF ANOTHER PERSON? ☐ Yes ☐ No	IF YES, PLEASE DESCRIBE:
COULD YOU HAVE PREVENTED YOUR INJURY? ☐ Yes ☐ No	IF YES, HOW?
WAS THERE ANY DEFECT/MALFUNCTION/PROBLEM OF/WITH THE EQUIPMENT OR WORK PROCEDURES? ☐ Yes ☐ No	IF YES, PLEASE DESCRIBE:

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

NAME OF PHYSICIAN:	ADDRESS:
NAME OF ATTENDING FACILITY:	ADDRESS:

SUPERVISOR NAME:	NOTE - If you do not receive medical treatment as the result of this injury or occupational illness, you must promptly notify your supervisor: • if you experience any complications resulting from your injury/illness. • if you are unable to perform your normal duties or absent yourself from your regular assignment because of this injury/illness. • before visiting a health care professional for subsequent treatment or observation due to your injury.

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

IMPORTANT: LIST ALL PERSONS WHO WITNESSED THE INJURY OR WHO CAN GIVE ANY INFORMATION ABOUT IT:

NAME	OCCUPATION	ADDRESS (Show Street and City)

Signed	Date

PLEASE ANSWER ALL QUESTIONS (USE REVERSE SIDE IF NECESSARY)