PORT TERMINAL RAILROAD ASSOCIATION
REPORT OF PERSONAL INJURY OR OCCUPATIONAL ILLNESS

Rev. 5/2011

GENERAL RULE 18.2 - PORT TERMINAL RAILROAD ASSOCIATION OPERATING RULE STATES: Employees injured while on duty and who remain on duty through the end of their daily shift or tour of duty must complete prescribed forms, giving time, place and cause of injury before the end of their shift or tour of duty. Employees who have injuries severe enough to preclude them from finishing their shift or tour of duty will complete and furnish prescribed forms, as above, as soon as practicable after their injury. In all cases of injury, the employee must also give his immediate supervisor prompt verbal notice of injury as soon as possible, but in no case later than end of shift or tour of duty. Under no circumstances should an injured employee depart company property without reporting verbally to the proper authority and securing permission to depart the property.

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 EMPLOYEE ID NUMBER:	(11) YOUR SUPERVISOR'S 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, YARD/TRACK, SUBDIVISION)	(6) WEATHER: (CLEAR, CLOUDY, RAIN, SNOW, SLEET, FOG, OTHER AND TEMPERATURE)	(7) VISIBILITY: (DARK, DAWN, DAYLIGHT, DUSK, OR ARTIFICIAL LIGHTING)

(8) WERE YOU INJURED ON DUTY, ON COMPANY PROPERTY, OFF DUTY, 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? YES OR NO (IF YES, PROVIDE DETAILS, INCLUDING EQUIPMENT ID NUMBERS)

(4) DID WORKING CONDITIONS CAUSE OR CONTRIBUTE TO THE CAUSE OF THE ACCIDENT/INJURY? YES OR NO (IF YES, PROVIDE COMPLETE DETAILS)

(5) DID OTHER PERSONS CAUSE OR CONTRIBUTE TO THE CAUSE OF THE ACCIDENT/INJURY? YES OR 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/INJURY:

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? (INCLUDE WHETHER ON THE LEFT OR RIGHT SIDE OF BODY OR BOTH)

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

(7) TREATMENT REQUIRED: (NONE, FIRST AID TREATED & RELEASED, X-RAYS, HOSPITALIZED, OR OTHER (EXPLAIN) (IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL)

(8) WHAT TREATMENT WAS GIVEN?

(9) MEDICATION INSTRUCTIONS: WAS A PRESCRIPTION WRITTEN? YES OR NO (IF YES: MEDICATION DOSAGE) IF NO PRESCRIPTIONS WERE WRITTEN, WERE OTHER MEDICATIONS ISSUED OR RECOMMENDED? YES OR NO (IF YES: MEDICATION DOSAGE)

(10) INDICATE YOUR CURRENT HEALTHCARE COVERAGE PLAN:

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/INJURY

(5) WAS EQUIPMENT ON MAIN, YARD TRACK, OR INDUSTRY TRACK AND DIRECTION OF?

(6) WERE THERE ANY DEFECTS IN THE EQUIPMENT? YES OR NO

(7) IF THE ANSWER TO QUESTION 6 IS YES, STATE THE NATURE OF THE DEFECTS AND IDENTIFY THE DEFECTIVE EQUIPMENT:

(8) WERE THE DEFECTIVE CONDITIONS MARKED? YES OR NO

(9) DID THIS ACCIDENT/INJURY RESULT FROM RIDING ON, BOARDING, DETRAINING FROM, OR BEING STRUCK OR RUN OVER BY MOVING EQUIPMENT? YES OR NO (IF YES, INDICATE WHICH)

(10) COMMENTS:

I certify that the foregoing information is true and correct.

Signature of Employee ______________________ Signature of Witness ______________________

Date Completed ______________________ Printed Name of Witness ______________________