EXHIBIT EE

TA12-375

MTA New York City Transit

ON THE JOB INJURY FORM

Report Date: 3/2/12

NOTICE:
Employee & Supervisor: Department must call in employee injury within 24 hours of injury. (1-888-682-4301) Complete this form upon occurrence of injury or recurrence of injury on duty and make three (3) photocopies.

Supervisor: MANAGERS INVESTIGATION ATTACHED — Complete the Department Section on front side of form, Employee's Section if applicable, and Investigation Form on reverse side. FAX BOTH SIDES OF FORM TO Workers' Compensation Unit 718-694-3281/3807 and to System Safety (646) 252-5793. Send original within two business days to Workers' Comp., 130 Livingston Street, 10th floor. Send copy to the Dept. Injury Reporting Unit; and keep 1 copy.

Employee: Complete Employee Section and Differential Application on front side of this report and keep 1 copy.

PLEASE PRINT – FULLY ANSWER ALL QUESTIONS AND BOTH SIDES OF FORM

MTA-NYCT ☒ MABSTOA ☐ UNION AFFILIATION: SSSA

EMPLOYEE'S SECTION (If employee is not available, Supervisor must fill out and sign form)

Name: Last Woitovich First Paul M.I. Pass/Payroll #: 979751 Soc. Sec. #: ***-**-4241
Home Address (& Apt. #): 28 Crescent Dr. N Home Phone: (718) 819-7099 Date of Birth 11/1/55
City: Farmingdale State: NY Zip Code: 11735 Sex (M/F) M
Job Title: MTCE SUPV. V&O Title Code: 6114 Date of Hire 11/19/79
Dept./Division: Subways/Sta. Env. Resp. Ctr. #: 2659 Date Supervisor Notified: 3/2/12 Hrs Worked Day of Inj: 2.5 Hrs Worked Prior 7 Days: 40
Pre-Injury Work Status: Recurrence of Prior Injury? Y: ___ N: ✓ Unknown: ___ Date of Prior Injury: N/A RDOs S/S
Full: ✓ Rest. No Work: ___ Hrs. of Duty: 800-1600 Wages/Hr: 37.100 Work Hrs/Day: 8 Work Hrs/Week: 40 Scheduled Lunch: 12-1230

DESCRIBE INJURY

Inj. Date: 3/2/12 Time: 10:30 (AM) PM (circle one) Date of Death (if applicable): N/A / /
Location/Facility/Station/Building/Depot: 235 6145 (VENT Bay) Area/Booth/Vehicle #/Track N/A County NY
What were you doing when injured or when injury recurred? Descending ladder
How did injury/exposure occur? Ladder slipped from under employee & he injured his ankles/feet
What object or substance directly harmed the employee? Ladder/VENT FAN
Why did injury occur? oil/grease on floor of vent bay caused ladder to slip
Nature of injury: (type of injury AND part of body) injured both ankles. Broke both heels
Medical Treatment Requested? Y: ✓ N: ___ Received Workers' Comp. Statement of Rights? Y: ✓ N: ___
Received Injury on Duty Instruction Sheet? Y: ✓ N: ___

Please be advised that in the event of a lost time injury greater than 30 days. (greater than 15 days for DOB employees), lost time relating to the on-the-job injury will be designated as leave usage under the Family Medical Leave Act (FMLA) if you are otherwise eligible. This notice does not constitute a waiver of any right that the Transit Authority has to controvert the claimed on-the-job injury.

Employee Signature: Paul Woitovich Date: 3/2/12 Supv. Signature: ___ (if employee fails to sign)

DIFFERENTIAL APPLICATION

Employee must sign Differential Application to begin processing. Signature does not denote agreement with Supervisor's Report nor Workers' Compensation determinations of eligibility.

I understand that, in making this application for Differential Benefit, I have agreed that the Authority may seek to recoup the value of Differential Benefits paid from any judgment or settlement of an action against third parties I may institute as a result of this Injury.

I hereby apply for payment of differential

Employee's Name (please print) Paul Woitovich Employee's Signature: P. Woitovich Date 3/2/12

DEPARTMENT SECTION

TELEPHONIC CONTROL # 12-0521

DATE REPORT TO MAC FOR DRUG/ALCOHOL TESTING: / /

Was injury observed?: Y: ✓ N: ___
If yes, was it job related?: Y: ✓ N: ___ Unk: ___
Date Stopped work: 3/2/12
Has injured returned to work? Y: ___ N: ✓

RULE COMPLIANCE: At time of injury was employee: Performing assigned duties? Y: ✓ N: ___

Return to work date: / / UNKNOWN

WAIVER & ELECTION REQUESTED: Y: ___ N: ✗ If yes, employee must complete Waiver & Election Form.

Supervisor Name: [illegible] Supv. Signature: [illegible] Date 3/2/12 Phone 212-712-[illegible]

Effective 3/2009

ON THE JOB INJURY INVESTIGATION FORM

RESPONSE **INJURED EMPLOYEE NAME:** Paul Bortolotti **PASS NUMBER:** 978751

INJURY INFORMATION
FIRST AID RENDERED: ☒yes ☐no Detail: EMS RESPONDED FIRST AT THE INJURY SCENE: M. DONOFRIO
AREA SECURED/IMMEDIATE HAZARD ELIMINATED: ☐yes Time: ☐no Why: Secured, but grease still present
IF TREATMENT GIVEN AWAY FROM WORKSITE, WHERE WAS IT GIVEN? FACILITY: Bellevue Hospital
ADDRESS: 462 1st Ave. City N.Y. State Ny Zip Code 10016
TREATED IN E/R? ☒yes ☐no HOSPITALIZED OVERNIGHT?: ☐yes ☐no
NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL:

FACT-FINDING
WITNESS INFORMATION
INJURED EMPLOYEE INTERVIEWED: ☒yes Date: 3/2/12 ☐no Why:
NAME, PASS NUMBER, JOB TITLE OF ALL WITNESSES:
M. DONOFRIO DATE INTERVIEWED: 3-2-12
A. PALLADORO DATE INTERVIEWED: 3-2-12

INJURY SCENE INFORMATION
LOCATION DETAIL: Train - work/passenger/other ____ # ____ Yard ____ Tower ____ Track # ____ Station ____ Shop ____
Bus - passenger/other ____ Bus # ____ Depot ____ Storeroom # ____ Street ____ Vehicle # ____
Other: VENT Bay @ 235 E. 14 ST.
PHOTOGRAPH TAKEN: ☒yes ☐no Why? ____ SKETCH MADE: ☐yes ☒no Why? PHOTOS TAKEN
DETAIL OF INJURY SCENE:
LIGHTING CONDITIONS: ☒good ☐poor ☐other ____ WEATHER: ☐clear ☒cloudy ☐rain ☐snow ☐other ____
STRUCTURAL ELEMENTS (hole in floor, chipped stair, missing handrail, etc.) ☒good ☐poor Detail:
HOUSEKEEPING: ☐good ☒poor Detail: GREASE IN AND AROUND VENTS OTHER: Oil & grease present.
EQUIPMENT/MACHINE/TOOL INVOLVED
NAME (include identification number if applicable) Ladder CONDITION: ☒good ☐poor OTHER:

ANALYSIS
PEOPLE/PROCEDURES
POLICY/PROCEDURE APPLICABLE: ☒yes ☐no FOLLOWED: ☒yes ☐no
TRAINING REQUIRED: ☐yes ☒no COMPLETED: ☐yes ☒no
PERSONAL PROTECTIVE EQUIPMENT REQUIRED: ☒yes ☐no IN USE: ☒yes ☐no
CONDITION OF PPE: ☒good ☐poor Detail Shoes, helmet, gloves, glasses OTHER:

EQUIPMENT
FAILURE: ☐yes ☒no CAUSE OF FAILURE: IMPROPER OPERATION: ____ LACK OF MAINTENANCE: ____ OTHER: ✓
MACHINE/TOOL USED CORRECTLY: ☐yes ☐no INSPECTION REQUIRED: ☐yes ☐no LAST INSPECTION: ____
SAFEGUARDS REQUIRED: ☐yes ☒no IN PLACE: ☐yes ☐no IN USE: ☐yes ☐no

MATERIAL
EXPOSED TO: N/A CONTACT WITH: N/A USED CORRECTLY: ☐yes ☐no
SAFEGUARDS REQUIRED: ☐yes ☐no IN PLACE: ☐yes ☐no IN USE: ☐yes ☐no

ENVIRONMENT
HEAT RELATED: ☐yes ☒no COLD RELATED: ☐yes ☒no OTHER: ☐yes ☐no ____
SAFEGUARDS REQUIRED: ☐yes ☐no IN PLACE: ☐yes ☐no IN USE: ☐yes ☐no

MISCELLANEOUS CONTRIBUTING FACTORS
OTHER EMPLOYEES: N/A INJURED EMPLOYEE DISTRACTED: N/A DRUG/ALCOHOL: N/A OTHER:

ROOT CAUSE OF INJURY (Why did injury/exposure occur?)
Oil & grease Present under foot of ladder. (Poor Housekeeping)

RECOMMENDATIONS
ACTION PLAN TO PREVENT RECURRENCE (What can be done to prevent another similar injury?)
Ensure floor in vent is clean. Mechanically secure ladder.
ACTION PLAN IMPLEMENTED: ☐yes ☐no DATE: ____ COMPLETED: ☐yes ☐no DATE: ____
COMMUNICATED RESULTS AND RECOMMENDATIONS
EMPLOYEES: ☐yes ☐no DATE: ____ OTHER DIVISIONS: ☐yes ☐no DATE: ____

ILLNESS CASES ONLY: **Check this box → ☐← if the employee independently and voluntarily requests that his or her name not be entered of the log. If checked, treat as a privacy concern case.**

INVESTIGATOR NAME: A. Danylchuk (Please print) SIGNATURE: A Danylchuk PASS # 199725
LOCATION MANAGER: NAME: A. Danylchuk (Please print) SIGNATURE: A Danylchuk
2012 MAR -2 PM 1:22
PASS # 199725 PHONE # 212-712-3747 REV: 5/25/07
Effective 3/2009

NEW YORK CITY TRANSIT
ON THE JOB INJURY MANAGEMENT FOLLOW-UP FORM

Employee Name: Paul Woitovich
Title: M/S1 V&D
Pass Number: 978751
Department/Division: Subways / Sta. Env.
Division RC: 2659
Work Location: 2 Nd.
Telephone: 212-712-3739

Manager Name: Andrew Danyluk
Title: Supt.
Pass Number: 199725
Department/Division: Subways / Sta. Env.

Date of injury: 3-2-12
Description of injury: Employee was inspecting vent bay when extension ladder slipped out from beneath him causing him to fall

Action Taken:
☒ Emergency Room
Hospital: Bellevue Hospital
Address: 462 First Ave. N.Y., N.Y.
Telephone:
Physician:
☐ Medical Assessment Center (MAC), or
☐ Independent Medical Examiner (IME)
Location:
Physician:
Telephone:

☐ Personal Physician
Name:
Address:
Telephone:

Other, explain:

Employee condition: Employee has 2 broken heels.

☐ Non- work related condition identified, explain:

Can employee work the following day? ☐ Yes ☒ No
If No, when can employee return to work? Unknown
If return date is unknown, when is employee's next evaluation? Unknown

☐ Contact day of employee:
☐ Full duty: perform routine tasks
☐ Restricted, explain:

☐ Restricted work available
☐ Restricted work unavailable
☐ Return to full work Date:
☐ Employee failed to report to full work Date:
☐ Employee failed to keep MAC/IME visit Date:

Manager's Signature

Date 3-2-12

New York City Transit

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