

UPRR COVID-19 UPC Visitor Office Access

The safety of our employees, supplier partners, customers, families and visitors remain Union Pacific's (UP) overriding priority. As the coronavirus disease 2019 (COVID-19) outbreak continues to evolve and spreads globally, UP's Health and Medical Services (HMS) is monitoring the situation closely and will periodically update company guidance based on current recommendations from the Centers for Disease Control and Prevention and the World Health Organization.

Only business critical visitors are permitted at any UP facility at this time. To prevent the spread of COVID-19 and reduce the potential risk of exposure to our workforce and visitors, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone in this building. Thank you for your time.

Visitor's Name: _____ Personal Phone Number (mobile/home): _____

Visitor's Company/Organization: _____ Name of Union Pacific Host: _____

Self-Declaration by Visitor

Have you returned from international travel within the last 14 days? Yes No

Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days? Yes No

Have you experienced any cold or flu-like symptoms in the last 14 days (to include fever, cough, chills, muscle pain, sore throat, shortness of breath or difficulty breathing, recent loss of taste or smell, nausea, vomiting, or diarrhea)? Yes No

I acknowledge and agree to the following:

- I will bring and wear a face covering upon arriving and while in any hallways or public areas during my visit at the UP facility: Yes No
- I will cover any coughs or sneezes: Yes No
- I will engage in proper personal hygiene practices while on UP premises: Yes No
- I will engage in social distancing in any meetings or conference rooms and where social distancing is not practicable wear a face covering. Yes No
- ***I will contact UP's Health and Medical Services team at 402-544-7011 if I develop any flu like symptoms or am diagnosed with COVID-19 within 14 days after my visit to the facility.*** Yes No

*If I fail to adhere to the practices outlined above, I understand access to the facility will be **denied** and/or **revoked**.*

Signature (visitor)

Date: _____