



# Workers Compensation Injury / Illness Report

Employee Name: \_\_\_\_\_ S.S. No: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Occupation: \_\_\_\_\_ Job Duties: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Date of Injury / Illness: \_\_\_\_\_ Time of Injury / Illness: \_\_\_\_\_

Employee Start Time: \_\_\_\_\_ Return to Work Date: \_\_\_\_\_

Is Modified Duty Available? (Please check one)  Yes  No

Nature of Injury / Illness: \_\_\_\_\_

Part of Body: \_\_\_\_\_

How did the injury occur? (Please be specific): \_\_\_\_\_

Address where injury / illness occurred: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Production Company Name: \_\_\_\_\_ Project Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Concurrent Employment (name other employer): \_\_\_\_\_

Will Production take employee back to work?  Yes  No

Date of Employers' Knowledge: \_\_\_\_\_

Person reported to: \_\_\_\_\_ Title: \_\_\_\_\_

Is the claim questionable? (Please check one)  Yes  No

List any pre-existing injuries: \_\_\_\_\_

Did the employee seek medical attention?  Yes  No

Physician Name or Medical Facility: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Name and Contact: Cast & Crew Entertainment Services, LLC  
Workers' Compensation Department  
100 E. Tujunga Ave., 2<sup>nd</sup> Floor  
Burbank, CA 91502  
Tel: (818) 848-6022 Fax: (818) 848-4614  
[workcomp@castandcrew.com](mailto:workcomp@castandcrew.com)

**Please fax or email the completed copy of this report to Cast & Crew  
"WITHIN 24 HOURS" of knowledge of injury**