Cast & Crew
RISK MANAGEMENT SERVICES

WORKERS' COMPENSATION INJURY/ILLNESS REPORT

*** REQUIRED INFORMATION**

EMPLOYEE NAME * (Last, First)		
DATE OF INJURY *	TIME OF INJURY	DATE REPORTED TO EMPLOYER
PRODUCTION COMPANY NAME *	PROJECT NAME *	
PRODUCTION CONTACT NAME *	PRODUCTION PHONE NO. *	
PERSON REPORTED TO *	TITLE *	REPORTER'S E-MAIL ADDRESS *	PHONE NO. *

EMPLOYEE INFORMATION

EMPLOYEE NAME ,	SOC SEC NO. *	DATE OF BIRTH *
EMPLOYEE ADDRESS *		GENDER * ◯ M ◯ F
EMPLOYEE ADDRESS 2		MARITAL STATUS ◯ M ◯ S

CITY *	STATE *	ZIP CODE *	PHONE NO. *	E-MAIL
HIRE DATE	SHIFT START TIME ON DATE OF INJURY			
OCCUPATION *	SUPERVISOR NAME *	PHONE NO. *		

JOB DUTIES
(LIMIT 254 CHARACTERS)

CONCURRENT EMPLOYMENT

IS MODIFIED DUTY AVAILABLE? ◯ Yes ◯ No ◯ Unknown

WILL PRODUCTION TAKE EMPLOYEE BACK TO WORK? ◯ Yes ◯ No ◯ Unknown

ACCIDENT INFORMATION

HOW DID INJURY OCCUR *
(PLEASE BE SPECIFIC)

CAUSE (SELECT ONE)

DETAILED CAUSE
(SELECT ONE)

NATURE OF INJURY
(SELECT ONE)

SPECIFY OTHER NATURE OF INJURY/ILLNESS

PART OF BODY
(SELECT ONE)

INITIAL TREATMENT
(SELECT ONE)

DID THE INJURY RESULT IN DEATH? ◯ Yes ◯ No

IF YES, EMPLOYEE DEATH DATE

ACCIDENT SITE INFORMATION

ADDRESS WHERE INJURY / ILLNESS OCCURRED *

CITY * | STATE * | ZIP CODE * | COUNTRY *

IS THE CLAIM QUESTIONABLE? ◯ Yes ◯ No

IS THE EMPLOYEE EXPECTED TO MISS WORK? * ◯ Yes ◯ No ◯ Unknown

DATE EMPLOYEE LAST WORKED *

INITIAL DISABILITY START DATE

HAS EMPLOYEE RETURNED TO WORK? ◯ Yes ◯ No ◯ Unknown

RETURN TO WORK DATE

RETURN TO WORK CONDITION (SELECT ONE)

WAS THIS A PRE-EXISTING DISABILITY? * ◯ Yes ◯ No ◯ Unknown

IF YES, LIST:

MEDICAL FACILITY INFORMATION

DID THE EMPLOYEE SEEK MEDICAL ATTENTION? ◯ Yes ◯ No

MEDICAL FACILITY

PHYSICIAN NAME

ADDRESS

CITY | STATE | ZIP CODE | PHONE NO.

WITNESS INFORMATION

WAS THERE A WITNESS? * ◯ Yes ◯ No

WITNESS NAME | PHONE NO.

WAS THERE A SECOND WITNESS? ◯ Yes ◯ No

SECOND WITNESS NAME | PHONE NO.

ADDITIONAL INFORMATION

PLEASE LIST ANY ADDITIONAL COMMENCE BELOW. THIS AREA IS FOR ANY FURTHER EXPLANATION OF THE INCIDENT THAT YOU FEEL WAS NOT ALREADY CAPTURED.

Please submit via email or fax the completed copy of this report to Cast & Crew within 24 hours of knowledge of injury.

Cast & Crew Entertainment Services, LLC - Workers' Compensation Dept.
Tel: (818) 848-6022 Fax: (818) 848-4614 workcomp@castandcrew.com

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