Cast & Crew

CAPS
A Cast & Crew Entertainment Company

WORKERS' COMPENSATION INJURY/ILLNESS REPORT

*** REQUIRED INFORMATION**

EMPLOYEE NAME * (Last, First)

DATE OF INJURY *	TIME OF INJURY	DATE REPORTED TO EMPLOYER

PRODUCTION/EVENT COMPANY NAME *	PROJECT/EVENT NAME *
PRODUCTION /EVENT CONTACT NAME *	PRODUCTION /EVENT CONTACT 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 *

EMPLOYEE ADDRESS 2

GENDER * ◯ M ◯ F

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 return this form to:

Cast & Crew Entertainment **or**
CAPS, A Cast & Crew Company
2300 Empire Ave, 5th Floor
Burbank, CA 91504
Fax: 818.848.4614

You may also e-mail a scan of the completed and signed form to WorkComp@castandcrew.com.