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## Right of Refusal of Medical Aid

PRODUCTION/EVENT COMPANY \_\_\_\_\_

PROJECT/VENUE TITLE \_\_\_\_\_

This form has been given to you because you have refused or declined an initial offer of treatment or transportation for medical treatment to a health provider.

I, \_\_\_\_\_ hereby refuse the first aid treatment or transportation for medical treatment to a health provider for the illness or injury incurred by me on this date \_\_\_\_\_.

In signing this waiver, I relieve the production/event company and Cast & Crew/CAPS from any and all liability or damages resulting from this refusal to accept such first aid treatment.

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Employee Name (Print or Type)

Job Title or Position

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Employee Signature

Date

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Supervisor Signature

Supervisor Name (printed)

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Medic Signature

Medic Name (printed)

Should your condition require further medical treatment, please contact Cast & Crew immediately at [workcomp@castandcrew.com](mailto:workcomp@castandcrew.com). Please submit via email or fax the completed copy of this form to Cast & Crew within 24 hours of knowledge of injury.

Cast & Crew Entertainment Services, LLC- Workers' Compensation Department  
Tel: 818.848.6022 Fax: 818.848.4614 [workcomp@castandcrew.com](mailto:workcomp@castandcrew.com)

2300 Empire Avenue 5th Floor Burbank California 91504 T 818.848.6022 [www.castandcrew.com](http://www.castandcrew.com)

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TORONTO VANCOUVER