

## WORKERS' COMPENSATION INJURY/ILLNESS REPORT

(To be completed by injured employee's supervisor or a medic)

**\* REQUIRED INFORMATION**

Cast & Crew

CAPS, A Cast & Crew Company

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 *					GENDER * <input type="radio"/> M <input type="radio"/> F
EMPLOYEE ADDRESS 2					MARITAL STATUS <input type="radio"/> M <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		WILL PRODUCTION/EVENT TAKE EMPLOYEE BACK TO WORK? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	

### ACCIDENT INFORMATION

HOW DID INJURY OCCUR * (PLEASE BE SPECIFIC)
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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 MISSWORK? \*  Yes  No  Unknown

DATE EMPLOYEE LAST  
WORKED \*

HAS EMPLOYEE RETURNED TO WORK?  Yes  No  Unknown

RETURN TO WORK DATE

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

RETURN TO WORK CONDITION  
(SELECT ONE)

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.
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WAS THERE A SECOND WITNESS?  Yes  No

SECOND WITNESS NAME	PHONE NO.
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**CA EMPLOYED/RESIDENT ONLY**

DWC1 PROVIDED TO EMPLOYEE? Yes No IF YES, DATE:

**ADDITIONAL INFORMATION**

PLEASE LIST ANY ADDITIONAL COMMENTS 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 form to Cast & Crew.  
Cast & Crew Entertainment Services, LLC- Workers' Compensation Department  
Tel: 818.848.6022 Fax: 818.848.4614 workcomp@castandcrew.com