Skip this form if using the "Stars Intake" app to report

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 ☐ Media Services

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 * ◯ 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/EVENT 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 RESULTIN 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 *

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.

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: 818.738.9351 Fax: 818.848.4614 workcomp@castandcrew.com

DESCRIPTION OF EMPLOYEE'S JOB DUTIES

INSTRUCTIONS: This form shall be developed jointly by the employer and employee and is intended to describe the employee's job duties. The completed form will be reviewed to determine whether the employee is able to return to work. Note: Union employees may obtain and submit their job description from their local union if preferred.

Employee Last Name _____ Employee First Name _____ MI ____ Claim #: _____

Project Name _____ Job Location _____

Job Title: _____ Hrs. Worked Per Day _____ Hrs. Worked Per Week _____

Description of Job Responsibilities: (Describe All Job Duties):

Please check one: ☐ Union ☐ Non-Union

Project Start Date: _____

Project End Date: _____

Please provide the Union (Local) name/number: _____

1. Check the frequency of activity required of the employee to perform the job.

ACTIVITY (Hours per day)	NEVER 0 HOURS	OCCASIONALLY UP TO 3 HOURS	FREQUENTLY 3-6 HOURS	CONSTANTLY 6-8+ hours
Sitting	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Bending (neck)	☐	☐	☐	☐
Bending (waist)	☐	☐	☐	☐
Squatting	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Twisting (neck)	☐	☐	☐	☐
Twisting (waist)	☐	☐	☐	☐
Hand Use: Dominant hand: ◯ Right ◯ Left	☐	☐	☐	☐
Is repetitive use of hand	☐	☐	☐	☐
Simple Grasping (right hand)	☐	☐	☐	☐
Simple Grasping (left hand)	☐	☐	☐	☐
Power Grasping (right hand)	☐	☐	☐	☐
Power Grasping left hand)	☐	☐	☐	☐
Fine Manipulation (right hand)	☐	☐	☐	☐
Fine Manipulation (left hand)	☐	☐	☐	☐
Pushing & Pulling (right hand)	☐	☐	☐	☐
Pushing & Pulling (left hand)	☐	☐	☐	☐
Reaching (above shoulder level)	☐	☐	☐	☐
Reaching (below shoulder level)	☐	☐	☐	☐
Keyboarding with both hands	☐	☐	☐	☐

2. Please indicate the daily Lifting and Carrying requirements of the job: Indicate the height the object is lifted from floor, table or overhead location and the distance the object is carried.

	LIFTING					CARRYING				
	Never 0 hrs.	Occasionally up to 3 hrs.	Frequently 3-6 hrs.	Constantly 6-8+	Height	Never 0 hrs.	Occasionally up to 3 hrs.	Frequently 3-6 hrs.	Constantly 6-8+ hrs.	Distance
0 - 10 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
11 - 25 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
26 - 50 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
51 - 75 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
76 - 100 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
100+ lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____

Describe the heaviest item required to carry and the distance to be carried:

3. Please indicate if your job requires:

	YES	NO	(IF YES, PLEASE BRIEFLY DESCRIBE)
a. Driving cars, trucks, forklifts and other equipment?	○	○	_____
b. Working around equipment and machinery?	○	○	_____
c. Walking on uneven ground?	○	○	_____
d. Exposure to excessive noise?	○	○	_____
e. Exposure to extremes in temperature, humidity or wetness?	○	○	_____
f. Exposure to dust, gas, fumes, or chemicals?	○	○	_____
g. Working at heights?	○	○	_____
h. Operation of foot controls or repetitive foot movement?	○	○	_____
i. Use of special visual or auditory protective equipment?	○	○	_____
j. Working with bio-hazards such as: blood borne pathogens, sewage, hospital waste, etc.?	○	○	_____

Employee Comments

Employer Comments:

Employer Contact Name: _____ Employer Contact Title: _____

Manager or Supervisor Signature: _____ Date: _____