Right of Refusal of Medical Aid Questionnaire

PRODUCTION/EVENT COMPANY _____

PROJECT/EVENT 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.

Employee Name (Print or Type) Job Title or Position

Employee Signature Date

Supervisor Signature Supervisor Name (printed)

Medic Signature Medic Name (printed)

Should your condition require further medical treatment, please contact Cast & Crew immediately at 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: 818.738.9351 Fax: 818.848.4614 workcomp@castandcrew.com