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