WEB COPY

EntertainmentPartners
an employee owned company

# Injury Report Form
# Workers' Compensation

**PLEASE USE THIS FORM TO REPORT WORK-RELATED INJURIES OR ILLNESSES.** When an employee has been injured and wants to file a workers' compensation claim, please complete this form and fax or email it as soon as possible to: **818.559.3283 / claims@ep.com**. This should be done immediately upon knowledge of the injury. Do not delay for lack of information; additional details can fdlow later. Faxing or emailing is the fastest way to process a claim. If you do not have access to a fax or email, you may call in the info to 800.955.4878. **Failure to promptly report a claim can result in fines and penalties from the State.**

**Please Print**

## Employer

Show Name: _____ Production Company: _____

Injured Worker's Supervisor: _____ Cell: _____

Production Contact: _____ Cell: _____

## Employee

Name: _____ Cell: _____

SSN (LAST FOUR): XXX-XX-_____ DOB: _____ M ☐ F ☐ State Hired: _____ Date Hired: _____

Address: _____

Occupation on Production: _____ Wages: _____ Per: _____

## Work-Related Injury or Illness

DATE OF INJURY: _____ Time Employee Began Work: _____ AM ☐ PM ☐ Time of Injury: _____ AM ☐ PM ☐

### Injury

Location Name: _____ Location Phone: _____

Location Address: _____ County: _____

Specific activity employee was engaged in: _____

How did the accident/injury occur: _____

Object causing injury: _____ Type of Injury: _____

Body part(s) injured (right/left): _____

### Witness to Injury (please attach a separate page for additional witnesses)

Name: _____ Title: _____

Address: _____ Cell: _____

### Return to Work

Did employee return to work? Yes ☐ No ☐ Unknown ☐ Hiatus ☐ Layoff ☐

Prior to injury: 1) Next scheduled work date: _____ 2) Estimated termination date: _____

Date returned to work: _____ # full days lost: _____ Date of death: _____

### On-Site Treatment

Notice Only (no medical treatment beyond On-Site care)? Yes ☐ No ☐ Unknown ☐

On-Site (Set Medic/Studio Medical Facility): _____ Phone: _____

### Off-Site Treatment

Off-Site Medical Treatment Anticipated? Yes ☐ No ☐ Unknown ☐

Off-Site (Occupational Clinic): _____ Is facility an ER? _____

Address: _____ State: _____ Phone: _____

## Completed By

Person completing this form: _____ Today's date: _____

## Comments






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