ExtremeReach Crew Services
3601 W. Olive Ave.,
Burbank, CA 91505
818-729-0080

Supervisor Injury Report

Extreme Reach Crew Services
Worker Compensation Contact:
Aldo Cammarota
aldo.cammarota@extremereach.com
818-729-0080 x 28801 – P
818-562-3301 - F

1: (If an Emergency, skip to #2) Report all injuries to Extreme Reach Crew Services within **24-hours** of the incidence by contacting Aldo Cammarota in the Risk Management department; during regular working hours call 818-729-0080 EXT 28801, for after hours or Holidays call 818-217-5941.

2: Following notice of a work-related injury, please assist the injured employee by locating the nearest Occupational/Industrial medical facility. To find a local medical facility visit www.talispoint.com/firsthealth/?AE=997373505&CAID=GBMPN). The injured worker **MUST** be sent to the medical facility with a completed Medical Treatment Authorization Form. For additional assistance and/or forms please contact Aldo Cammarota.

3: Please submit this fully completed form to the attention of Aldo Cammarota in the Risk Management department within **24-hours** of the incidence. Keep copies of all records for your files and mail the original forms to Extreme Reach Crew Services at **3601 W. Olive Ave., Ste 500, Burbank, CA 91505.**

1. Production Company Name: _____
2. Project Name: _____
3. Name of Supervisor (Last, First): _____ Telephone Number: _____
4. Name of Injured Employee (Last, First): _____
5. Employee's Telephone Number: _____
6. Employee's Social Security Number: _____
7. Employee Job Title & Duties: _____
8. Date of Hire: _____ Last day contracted to work on set/project? _____
9. Days Scheduled to Work (Check all boxes that apply): ☐ S ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sat
10. Normal Hours Worked: _____ ☐ AM ☐ PM to: ☐ AM ☐ PM
11. Time Injury Occurred: _____ ☐ AM ☐ PM Date Injury Occurred: _____
12. Time you were notified of the Injury: _____ ☐ AM ☐ PM Date you were notified: _____
13. Did the accident/exposure take place on the employer's premises? ☐ YES ☐ NO
14. Address where accident/exposure took place (123 N. Blank St.):

_____

Workers' Compensation fraud is a felony offense.
If you have any suspicions regarding the legitimacy of a claim, please notify the Extreme Reach Crew Services Risk Management Department immediately.

15. Department where accident/exposure took place (kitchen stage, parking lot, etc.):

16. Physical description of accident location (i.e. wet floor, crowded, dark, etc.):

17. Did the injured employee complete shift? ☐ YES ☐ NO

18. Please describe the specific injury or illness and the body part(s) affected (i.e. broken middle finger on left hand, lower back strain, abrasion to right shoulder, etc.)?

18a. Is this claim OSHA reportable? YES NO

19. Did anyone witness the injury occur? If so please have the witness(s) write down their statement (if possible) as well as their name & telephone number:

20. What was the employee doing at the time the injury occurred?

21. Equipment and/or materials Involved in Incident (i.e. dolly, camera, hammer, ladder, etc.)

22. Were there any safeguards or protective equipment in place and/or provided? (Signage, yellow tape, eye goggles, gloves etc.) If yes, please list:

23. Have there been any behavioral or performance issues with this employee? If so please explain in detail.

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24. Is there any evidence to suggest drugs/alcohol were involved in the injury? If so, explain why:

25. Do you question the validity of this injury? If so, explain why:

26. Was the injured employee sent to seek treatment? ☐ YES ☐ NO
If yes, please list:

Medical Facility Name & Address:

Telephone Number:

27. Was the employee taken via ambulance? ☐ YES ☐ NO

28. Should the employee require modified duty, would they be accommodated? ☐ YES ☐ NO

29. Was the employee off work for at least one full day after the injury? ☐ YES ☐ NO

30. If yes, what was the last day worked?

31. Has the employee returned to work? ☐ YES ☐ NO If yes, date returned to work

32. Is the injured employee employed elsewhere? ☐ YES ☐ NO ☐ UNKNOWN

33. Please describe the corrective action to be taken in order to prevent similar injuries from occurring:

34. Additional comments or concerns:

35. Form Completed By:

36. Title: Phone Number: Date:

THANK YOU FOR YOUR COOPERATION IN THIS SERIOUS MATTER!

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