Supervisor's First Report of Injury

1. **(If an Emergency, skip to #2)** Report all injuries to Extreme Reach within **24 hours** of the incident by contacting the Risk Management Department. During regular business hours, Mon-Fri 9am-6pm PST, call 818.568.1801, 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 https://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 the risk management department.

3. Please submit this fully completed form to our Risk Management department within **24 hours** of the incident. Keep copies of all records for your files and mail the original forms to Extreme Reach, Attn: Risk Management, 333 N. Glenoaks Blvd. Suite 300, Burbank, CA 91502.

Producer/AdAgency/Advertiser Name:	Project Name:
Supervisor Name (Last, First):	Supervisor Phone:
Name of injured Employee (Last, First):	Employee Phone:
Street Address:	City, State, Zip:
Employee D.O.B:	Employee SSN:
Employee Email Address (if available):	Employee job title & duties:
Date of hire:	Last day contracted to work on set/project?
Days scheduled to work (check all that apply): ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat	
Normal Hours worked: ☐ AM ☐ PM to: ☐ AM ☐ PM	
Date of Injury:	Time of Injury: ☐ AM ☐ PM
Date supervisor was notified:	Time supervisor was notified of injury? ☐ AM ☐ PM
Did the accident / exposure take place on the employer's premises? ☐ Yes ☐ No	
Street address where accident / exposure took place	City, State, Zip
Department where accident / exposure took place (kitchen, stage, parking lot, etc):	

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Physical description of accident location (ie. wet floor, crowded, dark, etc):

Did the injured employee complete shift?

☐ Yes ☐ No

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)

Is this claim OSHA reportable?

☐ Yes ☐ No

Did anyone witness the injury occur? If yes, please have the witness(es) write down their statement (if possible) as well as their name & phone number:

What was the employee doing at the time the injury occured?

Equipment and/or materials involved in incident (i.e. dolly, camera, hammer, ladder, etc)

Were there any safeguards or pretective equipment in place and/or provided (signage, yellow tape, eye goggles, gloves, etc) If yes, please list:

Have there been any behavioral or performance issues with this employee? If yes, please explain in detail:

Is there any evidence to suggest drugs/alchohol were involved in the injury? If yes, explain why:

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Do you question the validity of this injury? If yes, explain why:	
Was the injured employee sent to seek treatment? ☐ Yes ☐ No If yes, please list medical facility name: _____ Phone: _____ Address (including city, state, zip): _____	
Was the employee taken via ambulance? ☐ Yes ☐ No	
Should the employee require modified duty, would they be accomodated? ☐ Yes ☐ No	
Was the employee off work for at least one full day after the injury? ☐ Yes ☐ No	If Yes, what was the last day worked?
Has the employee returned to work? ☐ Yes ☐ No	If yes, date returned to work:
Is the injured employee employed elsewhere? ☐ Yes ☐ No ☐ Unknown	
Please describe the corrective action to be taken in order to prevent similar injuries from occurring:	
Additional comments or concerns:	
Form Completed by:	Title:
Phone:	Date:

Thank you for your cooperation in this serious matter. Workers' Compensation fraud is a felony offense. If you have any suspicions regarding the legitimacy of a claim, please notify the Extreme Reach Risk Management department immediately.

Questions? Contact us at riskmanagement@extremereach.com

Extreme Reach