XR EXTREME REACH

Supervisor's First Report of Injury

1. (If an Emergency, skip to #2) Report all injuries to XR 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 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 XR 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 protective 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 XR Extreme Reach Risk Management department immediately.

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