

# Employee Injury Report

- (If an Emergency, skip to #2)** Report all injuries to Extreme Reach Talent 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.
- To seek medical treatment, your supervisor must provide you with a completed medical treatment authorization form. Your supervisor will assist you with locating the nearest **approved** occupational / industrial medical facility by visiting <https://www.talispoint.com/firsthealth/?AE=997373505&CAID=GBMPN> or by contacting the Risk Management department for immediate assistance.
- 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, 3330 Cahuenga Blvd W., 4th Fl, Los Angeles, CA 90068.**

Producer/AdAgency/Advertiser Name:		Project Name:	
Employee Name:			
Social Security Number:		Date of Birth:	
Street Address		City, State, Zip	
Home Phone:		Cell Phone:	
Date of Hire (First day reported to work):		State employee was hired out of:	
Direct Supervisor:		Job Title:	
Job Duties:			
Days Worked (check all that apply): <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat			
Normal Hours worked: <input type="checkbox"/> AM <input type="checkbox"/> PM to: <input type="checkbox"/> AM <input type="checkbox"/> PM			
Date of Injury:		Time of Injury: <input type="checkbox"/> AM <input type="checkbox"/> PM	
Did employee complete shift the day of injury?		What time did employee start work on day of injury? <input type="checkbox"/> AM <input type="checkbox"/> PM	
Which state did injury occur in?			
Date employer was notified of injury:		Who was notified of injury?	

**CONTINUED**

Please describe the specific injury or illness and the body part affected (i.e. broken middle finger on left hand):

How did the accident occur? Describe the sequence of events; specify the object or exposure which directly produced the injury/illness (i.e. stepped on wet grass and lost balance, landed on my left wrist):

Did the accident/exposure take place on the employer's premises?

Yes  No

Address where accident/exposure took place (123 Blank St.):

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

Were there any witnesses?  Yes  No

If yes, please list: \_\_\_\_\_

Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Witness statement (please have any witnesses available provide their statement below; use additional paper if needed)

In your opinion, could this incident have been prevented? If yes, please explain why.

Have you ever been injured in the past while working? If yes, please explain.

Over the past 24 months, have you received any medical treatment? If yes, please indicate if it was work related.

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.

