CAPS
A Cast & Crew Entertainment Company

Incident Investigation/First Report of Injury

INSTRUCTIONS

1. This form should be completed by a Supervisor, not the Employee.
2. This form should be completed as soon as possible, and no later than 24 hours after the incident.
3. Once completed, this form can be faxed to 310-733-1802 or e-mailed to WorkersComp@capspayroll.com

INJURED WORKER INFORMATION	
Name:	Social Security No.:
Address:	City/State/Zip:
Phone number:	Date of birth:
E-mail address:	
❑ Male ❑ Female	Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed
	Wage Rate:
Date of Injury:	Time of Injury: : ❑ AM ❑ PM
Date and time reported by employee:	Injury reported to whom (name):
If reporting more than 24 hours after date of injury, please note reason:	
Start Time:	Occupation:
Date Hired:	State of Hire:
Employee's last scheduled date to work:	
Client Company:	Job/Project Name:
Client Address:	Client Phone:
Assistant Director/Supervisor/Lead Name:	Contact Number:

MEDICAL PROVIDER INFORMATION	
Name of Treating Clinic or Hospital:	
Address:	Phone:
Was an ambulance called? ❑ YES ❑ NO	
Does employee require additional treatment? ❑ YES ❑ NO	
Is employee missing time from work? ❑ YES ❑ NO	

10600 Virginia Avenue
Culver City, CA 90232
Phone: 310-280-0755
capspayroll.com

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ACCIDENT LOCATION

Incident's exact location and address (include location name, city, state and zip code):

Weather conditions:

Witness names and phone numbers:

Onsite Medic Name:	Onsite Medic Phone number:
Was this a vehicle accident: ❑ YES ❑ NO	Name of Other Driver:

3rd Party's Insurance Company and Policy # (if applicable):

Was a police report filed? ❑ YES ❑ NO If yes, please indicate police report number

INJURY INVESTIGATION

Describe in detail how the injury/illness occurred:	
Nature of Injury/Illness (e.g. strain, laceration, contusion):	
Part(s) of body affected (include left or right side of body):	
List direct cause(s). (e.g. Improper lifting technique, Poor housekeeping):	

Is surveillance or video available?:	❑ YES	❑ NO	❑ ATTACHED
Are photos of the accident location available?:	❑ YES	❑ NO	❑ ATTACHED
Are photos of the equipment related to the incident available?:	❑ YES	❑ NO	❑ ATTACHED

PERSON COMPLETING FORM

Name/Title (Please print) **Phone**

Signature **Date**

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Voluntary Statement

Name:	Phone number:
Injured Employee Name:	Date of Loss:

Relationship to Injured Employee: ❑ Self ❑ Witness ❑ Onsite Medic ❑ Supervisor

Describe the details of the incident (attach additional sheets if necessary):

I have reviewed this statement of _____ page(s) and believe it to be true and accurate to the best of my recollection. I understand this voluntary statement may be used as legal documentation.

Signature	Today's Date

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