REVOLUTION
ENTERTAINMENT SERVICES

we do more

WORKERS' COMPENSATION

WORKPLACE ACCIDENT / INJURY

INFORMATION

&

REPORTING PROCEDURES

818.562.7866

revolutiones.com | claims@revolutiones.com

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WORKERS' COMPENSATION GENERAL GUIDELINES

Dear Valued Client,

Please take a moment to review the contents of this packet which contains important information on:

- **Reporting Workers' Compensation claims** in the event of a work-related injury or illness
- **Medical Provider Network (MPN)** and Pharmacy
- **OSHA Regulations**
- **Injury and Illness Prevention Program** information
- **Other valuable information** designed to make your job easier

TO REPORT A WORKERS' COMPENSATION CLAIM

- **Do not delay** reporting an injury for lack of information. It is better to **email** claims@revolutiones.com the details right away and let the insurance company obtain the rest of the information after the claim is reported. Forms requiring completion by both employee and production company are enclosed.
- **Please note that Employers are subject to fines for late reporting of Workers' Compensation claims.** Any fines that result from a production company not promptly reporting the claim to Revolution will be the responsibility of that production company.
- Reporting a claim to Revolution **does not mean the claim has been accepted for coverage**. The adjuster at the insurance company will make that determination.
- Reporting a claim to Revolution **does not satisfy OSHA** requirements. The production must notify the appropriate state office of any serious injury, fatality, or hospitalization. OSHA's website is www.osha.gov and Cal/OSHA's is https://www.dir.ca.gov/dosh/.
- **If it's a life-threatening emergency, call 911 or go to emergency care.**

TO REQUEST A WORKERS' COMPENSATION CERTIFICATE OF INSURANCE

Please email certs@revolutiones.com and include in your request:

- Production company and show/event name
- Production office address
- Full name and address of any third party requesting to be named as certificate holder, if applicable
- Identify any special activity such as stunts or abnormal situations concerning the show/event

STATE-SPECIFIC INFORMATION

Some states require special documents be completed when an employee is injured in or is a resident of that perspective state. States may also require posting of certain notices. Please check for any state mandated requirements.

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When an Accident / Injury occurs, please immediately contact:

CLAIMS HOTLINE

818-562-7866

claims@revolutiones.com

If it's an emergency or you feel that it's a life-threatening matter, please contact 911 or visit Emergency Care.

If it is not an emergency, please visit the nearest Urgent Care facility or review the MPN website for participating clinics.

All accidents causing injuries must be reported to Revolution within 24 hours, despite the lack of information available or if the employee waived treatment. Timely reporting is essential for a complete and thorough investigation to be completed and determination of benefits made. Additionally, timely reporting supports our efforts to provide you and your employees the best possible medical and disability management. We urge production companies to report the claim immediately.

OSHA requires reporting, by phone or email, to the nearest District Office of Cal/OSHA any serious injury, illness or death of an employee occurring in a place of employment or in connection with any employment. A serious injury or illness must be reported within 24 hours and now includes:

- requiring inpatient hospitalization, for other than medical observation or diagnostic testing; or
- resulting in an amputation, loss of an eye or any serious degree of permanent disfigurement

The report for a fatality must be made within 8 hours of when the employer knew, or should have known, about the fatality. It is advisable that production companies monitor an injured employee's condition and hospitalization following an incident to determine whether the injury or illness is or becomes reportable. It is important to note that any qualifying injury or illness, or a fatality, is reportable if it occurs in the workplace, even if it the cause is non-occupational, such as a heart attack. Failing to timely report a reportable in-hospitalization or other qualifying injury can be cited and could set up an employer for costly repeat violations. Thank you.

PLEASE PROVIDE TO MEDICAL PROVIDER IN CASE OF WORKPLACE INJURY.

Insured Employer:
Revolution Business Services, LLC (Revolution Payroll)
Address: 201 N. First St., B
Burbank, CA 91502
Phone: 818-562-7866
claims@revolutiones.com

Insurer:
Service American Indemnity Company, Inc. NAIC #39152
Policy Number: SAACWC0014300
Effective: 10/1/2020-10/1/2021
Address: P.O. Box 26850
Austin, TX 78755
Phone: 512-637-3100
Toll Free: 833-294-0968

State National Insurance Company, Inc. NAIC #12831
Policy Number: RLN0005800
Effective: 10/1/2020-10/01/2021
Policy States: ID/MN/NY
Address: 2502 N. Rocky Point Dr., Ste 400
Tampa, FL 33607
Phone: 813-639-3000

Adjuster: PMA Companies
Address: P.O. Box 5231
Janesville, WI 53547-5231
Fax: 800-432-9762
24/7 Call Center: 888-476-2669

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INJURED WORKER NOTIFICATION FORM

Attention Production Company: In the event of a work related incident or injury, please have the injured worker take a completed and signed copy of the attached form to the nearest medical facility, hospital or occupational clinic.

For employees of:

Revolution Payroll
201 N. First Street #B
Burbank, CA 91502

PHONE 818-562-7866

NOTICE TO MEDICAL PROVIDER
In an emergency situation, do not delay medical care. Our workers' compensation carrier reserves the right to verify compensability and authorize additional treatment beyond the initial diagnosis and emergency care.

Injury

Date of Injury:_____ Time: _____

Incident Location: _____

Body Part(s) Injured: _____

Employee

Name: _____

Signature:_____ Date:_____

Production Company

Name of Production Company: _____

Representative Name/Title: _____

Signature:_____ Date:_____

For more information on where to send bills and doctor reports, please contact Revolution Payroll at 818-562-7866 or the adjuster at: PMA Companies | P.O. Box 5231, Janesville, WI 53547-5231 | Phone: 888-476-2669

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Employee's Report of Work-Related Injury

Employee Information

Employee Name	Social Security Number	Home Phone Number: Cell Phone Number:
Home Address		
Date of Birth	Production Company	
Hire Date	How many hours do you normally work per week?	
Do you have other employment? ☐ Yes ☐ No	If yes, where?	

Work Related Accident

Date of Injury: Time of Injury:	Start Time: End Time:	Finished Shift: ☐ Yes ☐ No	Position:	Location of Injury:
Injury reported immediately? ☐ Yes ☐ No	If yes, to whom did you report it?	If no, why?		
Witnesses? ☐ Yes ☐ No	If yes, Witness #1 Name:	Witness # 2 Name:		
How did the accident occur? Describe the activity and any tools, equipment, or material you were using. (Example: I was opening a box of paper using a knife. The knife slipped on the surface of the box and cut the skin of my right index finger).				
What could have been done to prevent this injury? (example: by wearing protective gloves while using knife).				

Medical Treatment

Did you receive treatment? ____Reporting only. I declined treatment at the time treatment was provided. Please complete next page.
If you received treatment, who provided it?
Describe the treatment provided (example: cut was washed; antiseptic and bandage was applied)
What was explained to you by the Doctor about your injury/illness, if you met with a Doctor?
Where you given any work restrictions?
Have you had any other accidents, personal or work related, that could possibly be related to this injury? If so, please provide specific information.

By signing this form, the employee certifies that the information the employee has provided is true to the best of employee knowledge.	Employee Signature	Date

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Refusal of Medical Treatment

I,_____, injured myself as described below. I have been informed by my employer of my opportunity to seek medical treatment; however, I have chosen to **decline** medical attention at this time.

I understand that I have the option to see a physician at any time after my reported injury for up to one (1) year. If during this period I choose to seek medical treatment as a result of this injury/accident, I must notify my supervisor and/or my employer of my request.

Date of Injury: _____

Body Part(s) Injured: _____

Description Details:

_____

_____

_____

_____

_____ _____

EMPLOYEE NAME (PRINT) **DATE**

_____ _____

EMPLOYEE SIGNATURE **DATE**

_____

SOCIAL SECURITY NUMBER

_____ _____

COMPANY REPRESENTATIVE SIGNATURE **DATE**

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ACCIDENT REPORT OF WORK-RELATED INJURY

(to be completed by manager or supervisor)

EMPLOYEE INFORMATION

Name of injured employee: _____

Employee's hire date: _____ Scheduled to work through: _____

Occupation: _____ Pay Rate: _____

Gender: Male ☐ Female: ☐ DOB: _____ Union: Yes ☐ No: ☐

INJURY INFORMATION

Date of injury: _____

Address/location where injury occurred: _____

_____

Date injury reported: _____ If date is different from date of injury, please explain why?

_____

_____

Describe injury: _____

_____

Where and how did the accident occur? _____

_____

_____

_____

Did accident occur at injured employees assigned workstation/area? ☐ YES ☐ NO

If no, please explain why?

_____

_____

_____

How long has injured employee been performing this specific job?

_____

Was injured employee instructed on a safe way to do this job? ☐ YES ☐ NO

If yes, please explain why this accident occurred:

_____

_____

Was the injured employee performing the tasks he/she was assigned to do? _____

Who trained the employee? _____

Were any safety rules violated? _____ If yes, which one and why?

_____

_____

If lifting was involved, obtain exact weight of object: Weight _____ Height _____

How high it was lifted: Object was lifted from _____ to _____

What was the object? _____

What has been done to prevent such an accident recurring?

_____

_____

_____

Do you have any recommendation to prevent such an accident from occurring again?

_____

_____

Was there a medic on set? _____ Was medical treatment sought? _____

Did the employee return to work? _____

If taken to a medical facility or hospital, please provide name and location of facility or hospital:

_____

_____

PRODUCTION COMPANY INFORMATION

Completed by: _____ Signature: _____

Date: _____

Production Company Name: _____

Project Name: _____

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Witness Report of Accident/Injury

Name of Injured: _____

Date of Injury: _____

Name of Witness: _____

Were you in the area where the accident occurred? ☐ Yes ☐ No

Where exactly did the accident occur?

_____

Did you see the accident occur? ☐ Yes ☐ No

How exactly did the accident occur?

_____

_____

Was it obvious that the employee was hurt? ☐ Yes ☐ No

What part of the body was injured (be specific)?

_____

_____

Was the employee using a tool or piece of machinery? ☐ Yes ☐ No

Please describe:

_____

Have you ever heard the employee complain of a similar injury? ☐ Yes ☐ No

Have you ever heard the employee talk about on-the-job injury before? ☐ Yes ☐ No

Are you aware of any related accidents, personal or on-the-job, that this employee has had? ☐ Yes ☐ No

If yes, please describe:

_____

Did the employee violate a known safety rule? ☐ Yes ☐ No

Did you know for a fact that the employee was aware of the safety rule? ☐ Yes ☐ No

Do you know if the supervisor or anyone else ever cautioned the employee about unsafe work habits?

☐ Yes ☐ No

What do you think caused the accident? Check those that apply.

- ☐ Unguarded equipment
- ☐ Employee carelessness
- ☐ Deliberate violation of safety rule
- ☐ Another employee
- ☐ Non-employee
- ☐ Horseplay
- ☐ Poorly maintained equipment
- ☐ Pressure to work faster

What can be done to prevent a similar accident in the future? _____

_____

Comments _____

_____

Acknowledgement:

As certified by my signature below, I affirm that all information on this report is true to the best of my knowledge. I understand that workers' compensation fraud is a felony offense and our company will prosecute anyone who commits fraud or participates in fraud.

_____ _____

Witness Signature Date

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Production Set Medic Report

In addition to their Health and Safety responsibilities, Set Medics are responsible for gathering and recording injury and illness-related information required by state and federal law and Production Company policy. Regardless of payroll company, your Production Office Coordinator needs information on every employee who suffers a work-related injury or illness.

Please provide this sheet to the Set Medic so they can document how the injury occurred and what measures were taken to address it.

To be completed by Set Medic:

Set Medic Name:_____
Date:_____