REVOLUTION
ENTERTAINMENT SERVICES

we do more

WORKERS' COMPENSATION

WORKPLACE ACCIDENT / INJURY

INFORMATION

&

REPORTING PROCEDURES

818.562.7866

revolutiones.com | claims@revolutiones.com

PLEASE PROVIDE TO MEDICAL PROVIDER IN CASE OF WORKPLACE INJURY.

Insured:
Revolution Business Services, LLC

201 N. First St., B
Burbank, CA 91502
818-562-7866
claims@revolutiones.com

Insurer: State National Insurance Company, Inc. NAIC#12831
Policy Number: AMW-049-0001-001
Effective: 12/31/19-10/01/2020

WORK-RELATED ACCIDENT / INJURY SUBMISSION FORM

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 call 911 or visit urgent care.

All work-related 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 our client production companies to report the injury 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.

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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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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

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**