Injury Report Form
Workers' Compensation

PLEASE CALL 855.234.1975 OR USE THIS FORM TO REPORT WORK-RELATED INJURIES OR ILLNESSES. When an employee has been injured please call 855.234.1975 (option 1) to report your injury, 24 hours a day and speak with a nurse practitioner, or complete this form and email or fax it as soon as possible to: claims@ep.com / 818.559.3283. This should be done immediately upon knowledge of the injury. Do not delay for lack of information; additional details can follow later. Calling 855.243.1975 is the fastest way to process a claim and receive a reference number. If you have any questions you can reach the EP Work Comp Department at 800.955.4878. **Failure to promptly report a claim can result in fines and penalties from the State.**

Please Print

Employer

Show Name: _____ Production Company: _____

Injured Worker's Supervisor: _____ Cell: _____

Production Contact: _____ Cell: _____

Employee

Name: _____ Cell: _____

SSN (LAST FOUR): XXX-XX-_____ DOB: _____ M ☐ F ☐ State Hired: _____ Date Hired: _____

Address: _____

Occupation on Production: _____ Wages: _____ Per: _____

Work-Related Injury or Illness

DATE OF INJURY: _____ Time Employee Began Work: _____ AM ☐ PM ☐ Time of Injury: _____ AM ☐ PM ☐

Injury

Location Name: _____ Location Phone: _____

Location Address: _____ County: _____

Specific activity employee was engaged in: _____

How did the accident/injury occur: _____

Object causing injury: _____ Type of Injury: _____

Body part(s) injured (right/left): _____

Witness to Injury (please attach a separate page for additional witnesses)

Name: _____ Title: _____

Address: _____ Cell: _____

Return to Work

Did employee return to work? Yes ☐ No ☐ Unknown ☐ Hiatus ☐ Layoff ☐

Prior to injury: 1) Next scheduled work date: _____ 2) Estimated termination date: _____

Date returned to work: _____ # full days lost: _____ Date of death: _____

On-Site Treatment

Notice Only (no medical treatment beyond On-Site care)? Yes ☐ No ☐ Unknown ☐

On-Site (Set Medic/Studio Medical Facility): _____ Phone: _____

Off-Site Treatment

Off-Site Medical Treatment Anticipated? Yes ☐ No ☐ Unknown ☐

Off-Site (Occupational Clinic): _____ Is facility an ER? _____

Address: _____ State: _____ Phone: _____

Completed By

Person completing this form: _____ Today's date: _____

Comments