

Employee Injury Report

1. (If an Emergency, skip to #2) Report all injuries to Extreme Reach 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.

2. 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.

3. 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, 333 N. Glenoaks Blvd. Suite 300, Burbank, CA 91502.

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	
Direct Supervisor		Employee Job Title	
Employee 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?	

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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.

Questions? Contact us at riskmanagement@extremereach.com

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