Program Productions, Inc.

Employee Injury Reporting

In the event of an occurrence, (employee injury at work), the following steps should be taken immediately:

- Secure medical assistance for the injured person and dial 911 if emergency services are necessary.
- Arrange transport of injured employee to Medical Provider if applicable.
- Employee or employee representative to report the claim to **CHUBB** (Worker's Compensation Carrier) directly at **1-800-699-9916**.
    - Carrier will need the employer name: **Program Productions, Inc.**
    - Program Productions Policy #: **7174-9541**
- Insurance Carrier will provide a claim number that should be used for any provider services resulting from the occurrence.
- Preserve all evidence related to the occurrence. If possible, take cell phone photos of the accident scene immediately after the occurrence to show the conditions at the time of the accident and email to PPI Crew Coordinator and Human Resources at Program Productions, Inc.:
  HR@programproductions.com
- Obtain any witness names and contact information if applicable, and provide this information to the PPI Crew Coordinator and to Human Resources
- Employee to complete the **Employee Injury Report** Form and email PPI Crew Coordinator and HR@programproductions.com
- Human Resources will complete and file the **First Report of Injury** with insurance carrier
- Insurance carrier will reach out to the injured employee and potential witnesses to clarify details of the incident.
- Program Productions, Inc. will be in communication with carrier throughout the claims process.

Employee Injury Report

(to be completed by Employee)

Employee Name (Last, First, Middle Initial)

Company (PPI, XLT, etc.)

Current Position and length of time performing position

Date of Report

Incident Reported to:

Date of Injury

1. Nature of Injury (e.g., strain, cut, fracture, multiple injuries, etc.):

2. Body Part Injured (e.g., head, eye, leg, back, wrist, etc. Specific left/right, etc.):

3. How and Where Injury Occurred (struck by…, fell from…, exposed to…, etc.):

4. Explain Where Incident Occurred (e.g., floor, room, location, etc. Be specific):

5. Description of Incident – Explain Fully How Incident Occurred:

6. Witness to Incident:

I UNDERSTAND A WORKERS' COMPENSATION CLAIM WILL BE SUBMITTED ON MY BEHALF. SUBMISSION OF THIS CLAIM MAY RESULT IN MY RECEIPT OF WORKERS' COMPENSATION BENEFITS PURSUANT TO THE WORKERS' COMPENSATION ACT. ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY MATERIAL MISREPRESENTATION FOR THE PURPOSES OF OBTAINING WORKERS' COMPENSATION BENEFITS OR PAYMENT MAY BE GUILTY OF A CRIME.

Employee Signature Date