



Spotlight Payroll, Inc.

**Worker’s Compensation – First Report of Injury**  
Filing of this report does not affect your liability under the Workers Compensation Act and is not incriminatory in any sense.

Workers Comp/General Liability – Client Procedures:

- 1. Tend to injured employee. Contact on site emergency personnel - Medic (if available) or Fire/Rescue & Ambulance if necessary. If injury is not severe - employee may be taken to a Hospital’s Emergency Room or Medical Center for treatment.**
- 2. Notify Spotlight as soon as possible after accident occurs. PH# 312-252-5814 (alt # 847-767-4278 – after normal business hours)**
3. The on site Producer and/or Production Manager, Crew Chief (Steward), the injured employee (if possible) and a witness must fill out a copy of this form – AS COMPLETE & ACCURATE AS POSSIBLE – ON THE SAME DAY THE INJURY/INCIDENT OCCURED. If possible include pictures of accident site.
4. Upon completion, fax or scan and email all forms, documents and pictures to Spotlight’s Chicago office (fax #312-726-4405) to the attention of John Kramer (john@spotlight.net). Copies of all forms or documents given to the injured employee from a Medical Center or Hospital should also be forwarded to Spotlight when received.
5. The Local Union and/or Venue may have additional accident report forms to be filled out - please fax copies of these forms as well.
6. Claim number and policy information will be given directly to employee when available.

**Information Regarding Injured Party:**

Report Date: \_\_\_\_\_

Project/Show: \_\_\_\_\_

Name of Injured: \_\_\_\_\_

SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Alternate Phone #: \_\_\_\_\_

Gender:       Male       Female

Marital Status:     Single     Married     Divorced     Widowed

Birth Date: \_\_\_\_\_

No. of Dependents: \_\_\_\_\_

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**Information Regarding Injury:**

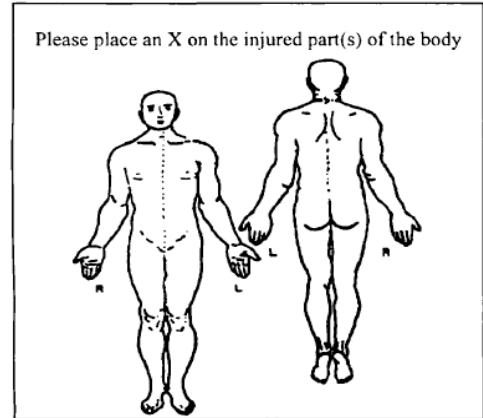
Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_

Did this result in:  Occupational Injury  Occupational Disease

Address of Location Where Injury or Exposure Occurred: \_\_\_\_\_

Type of Injury: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



What task was the employee performing when the injury occurred? \_\_\_\_\_

Object or substance responsible for injury or illness (source)? \_\_\_\_\_

How did Accident or Illness Occur (type)? \_\_\_\_\_

Name, Address and Phone Number of Hospital/Care Center: \_\_\_\_\_

Name, Address and Phone Number of Physician: \_\_\_\_\_

Name and Contact Phone Number's of Witnesses: \_\_\_\_\_

Report Prepared by: \_\_\_\_\_ Title/Relationship to Injured: \_\_\_\_\_

Signature: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_