Safety Responsibilities
SET MEDIC

NOTE: These are your Safety Program Responsibilities ONLY. For Workers Comp instructions, contact your Production Office Coordinator.

In addition to their Health and Safety responsibilities, Set Medics are responsible for gathering and recording injury and illness-related information required by state and federal law and Production company policy. Regardless of payroll company, your Production Office Coordinator needs information on every employee who suffers a work-related injury or illness.

Please remember that the forms you are required to fill out are legal documents, so be as accurate and thorough as possible.

When you start work:

1. Obtain *Location Set Medic Packet* from your Production Coordinator or payroll company.
2. **Download Forms 5020 and DWC-1** or local equivalent at **https://www.safetyontheset.com/set-medic-forms/**
3. Review the paperwork requirements.

Participate in the Injury & Illness Prevention Program:

1. Read and understand safety literature:
   a. Obtain and review the ***General Safety Guidelines for Production (Form 1),*** sign the ***Employee Acknowledgement Form*** and turn it in to the POC. Additional information is available from the IIPP Manual, which can be obtained at **www.safetyontheset.**com along with all **AMPTP Safety Bulletins** and other safety info.
   b. Read the distributed **AMPTP Safety Bulletins** related to the specific hazards that you may encounter on the production (i.e. helicopters, firearms, appropriate clothing, etc.)
2. Attend and participate in safety meetings to review the following:
   a. Safety aspects of the day's activities and the particular hazards of the location.
   b. Elements of the **Emergency Plan,** such as the location of emergency equipment, exits and telephones on site, and emergency procedures, such as evacuation plans in case of fire, nearest hospital name, location and phone number, etc.
   c. Set up your equipment accordingly.

IF AN INJURY IS SEVERE, DIAL 911 OR YOUR FACILITY'S EMERGENCY RESPONSE NUMBER FOR TREATMENT AND TRANSPORTATION OF THE PATIENT TO A HOSPITAL.
(Ensure the employee's supervisor has arranged for a return ride from the hospital.)
THEN IMMEDIATELY CALL THE UNIT PRODUCTION MANAGER. IF YOU CANNOT REACH THE UPM, CALL THE PRODUCTION OFFICE COORDINATOR AND THE PRODUCTION SAFETY REPRESENTATIVE IMMEDIATELY. YOU MAY LEAVE VOICE MESSAGES – BUT YOU MUST CONTINUE TO CALL UNTIL YOU SPEAK TO A LIVE PERSON.

Serious Accidents, Injuries and Mishaps

Serious accidents, injuries and mishaps are incidents that require transportation by ambulance, visitation to the hospital by one or more employees, any treatments greater than general first aid, or any serious property/asset damage.

For all serious injuries, the Set Medic/First Aid attendant must do the following:

1. **Notify the UPM of the injury.**
2. Fill out ***Employer's Report of Occupational Injury or Illness*** **(Form 5020)** or local equivalent. Record the patient's recounting of events in quotes. Do not speculate.
3. Send the completed Form 5020 (or local equivalent) to the **Production Safety Representative by** fax at (818) 954-2805 or by email.

4. Complete a ***Refusal of First Aid*** form if the employee refuses to be treated at the scene of the incident or transported to the hospital.

Non-Serious Injuries

If the injury is NOT severe, but requires medical attention:

1. Provide the employee with a medical authorization slip for the employee's payroll company.
2. Refer the employee to a clinic from the employee's payroll companies list of approved clinics. (If out of Southern CA, use the closest occupational health clinic or emergency room.)
3. Arrange for transportation of the employee to the clinic if the employee is not capable of driving.
4. For follow-up treatment, have the doctor's office of hospital contact the payroll company's Workers' Compensation Department for proper authorization. If referral to a specialist is needed, contact the Workers' Compensation Department and they will make the necessary arrangements.
5. Offer the employee **Form DWC-1** or local equivalent.
6. Complete **Form 5020** or local equivalent and fax it immediately to the employee's payroll company's Workers' Compensation Department and to your **Production Office Coordinator**.
7. Mail the original Form 5020 the Workers' Compensation Department of the employee's payroll company.

If the employee "may have been injured" or does not want to go to a clinic:

1. You must offer **Form DWC-1** or the local equivalent to the employee.
2. Tell the employee if he or she later decides to seek medical attention for the injury to first call his/her payroll company's Workers' Compensation Department.
3. You must complete (to the best of your knowledge) **Form 5020** or the local equivalent and send it to your Production Office Coordinator. When completing the form, record what the patient says. Do not speculate.
4. Document the injury on the Log Sheet and in your Nursing Notes.
5. Fill out the **Accident Investigation Report (Form 9)** and give it to the Production Office Coordinator.
6. If the patient refuses medical attention, fill out the **Right of Refusal of Medical Aid Form (Form 16)** and give it to the Production Office Coordinator.

Form 9 and Form 16 are for documentation of the Safety Program and are to be completed for every injury or illness in addition to any Workers Comp forms.

Document work-related injuries and illnesses:

1. **Log Sheets** – follow instructions below. At end of week, send ORIGINAL log sheets and nursing notes to your Production Office Coordinator.
   a. Use one log sheet for each day if patients are seen.
   b. If no patients are seen, use one sheet for several days (Write the date and "No Patients Seen.")
   c. Complete ALL information on log sheet –
      - DOI: Date of Injury
      - TOI: Time of Injury
      - MOI: Mechanism of Injury
      - LOI: Location of Injury
   d. Narrative – if you complete detailed nursing notes on a separate form, circle "yes" in the narrative column and return your original notes to the Production Office Coordinator.
   e. WC Packet – you are to give WC Packets to employees who sustain significant injuries, even if they decline further treatment at the time of the injury. Circle "yes" on the log to document the WC Packet.
2. **Work Comp (WC) Packet** and the procedures required are different for each payroll company. Contact your Production Office Coordinator or the payroll company at the beginning of production for the WC Packet and procedures for your show.

ACCIDENT INVESTIGATION REPORT

(Turn in to Production Office Coordinator)
FAX TO PRODUCTION SAFETY REPRESENTATIVE AT 818-954-2805 WITHIN 24 HOURS OF ACCIDENT

PRODUCTION TITLE:_____ DATE:_____

INJURED'S NAME:_____ CAST ☐ CREW ☐ OTHER ☐

DATE OF ACCIDENT:_____ TIME OF ACCIDENT:_____ am pm ☐

LOCATION OF ACCIDENT:_____

Type of Injury/Illness

(Check all that apply)

☐ **Fracture**	☐ **Amputation**	☐ **Head Injury**	☐ **1st Degree Burn**	☐ **Foreign Body in Eye**	☐ **Bite/Sting**
☐ **Strain**	☐ **Laceration**	☐ **Neck Injury**	☐ **2nd Degree Burn**	☐ **Contact Dermatitis**	☐ **Splinter**
☐ **Sprain**	☐ **Avulsion**	☐ **Back Injury**	☐ **3rd Degree Burn**	☐ **Allergic Reaction**	☐ **Nausea**
☐ **Dislocation**	☐ **Abrasion**	☐ **Abdomen Injury**	☐ **Tooth Injury**	☐ **Rash**	☐ **Illness***
☐ **Contusion**	☐ **Puncture**	☐ **Crushing Injury**	☐ **Hearing Loss**	☐ **Infection**	☐ **Other***

* Describe Illness or Other:_____

Injured Part of Body

(Check all that apply)

	☐ **Head**	☐ **Chest**	☐ **Shoulder**	☐ **Wrist**	☐ **Upper Leg**	☐ **Foot**	☐ **Eye**	☐ **Mouth**
☐ **Right**	☐ **Neck**	☐ **Ribs**	☐ **Upper Arm**	☐ **Back of Hand**	☐ **Knee**	☐ **Toe**	☐ **Nose**	☐ **Tooth**
☐ **Left**	☐ **Back**	☐ **Abdomen**	☐ **Elbow**	☐ **Palm of Hand**	☐ **Lower Leg**	☐ **Forehead**	☐ **Cheek**	☐ **Throat**
	☐ **Buttocks**	☐ **Pelvis Area**	☐ **Lower Arm**	☐ **Finger** (Digit_____)	☐ **Ankle**	☐ **Ear**	☐ **Chin**	☐ **Other***

* Describe Other:_____

Explain Cause of Accident and Nature of Injury: (DO NOT SPECULATE)

_____

_____

_____

Corrective Action Taken to Prevent Recurrence:_____

_____

_____

Witnesses, If Any: _____

Form Completed By (Print): _____ **Title:** _____

Signature: _____ **Date:** _____

RIGHT OF REFUSAL OF MEDICAL AID

Show Name: _____

I hereby refuse the first aid treatment recommended to me by the First Aid Person employed by my production for the illness or injury incurred by me on this date.

In signing this waiver, I release the First Aid Person, the Production and its personnel from any liability resulting from this refusal to accept such first aid treatment.

_____ _____
Injured's or Guardian's Signature Date

_____/_____ _____
Injured's Name (print) Injured's Cell # Job Title or Position

_____ _____
Guardian's Name in case of minor Relationship to Injured

_____
First Aid Person Signature

_____
First Aid Person Name (print)

_____
Witness Signature

_____/_____
Witness Name (print) Witness Cell #

This form should be signed, dated and returned to the Production Safety Representative.

NOTES: _____

_____

_____

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF NJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.

Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Please do not use this column

CASE NUMBER

OWNERSHIP

INDUSTRY

OCCUPATION

SEX

AGE

DAILY HOURS

DAYS PER WEEK

WEEKLY HOURS

WEEKLY WAGE

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

EVENT

SECONDARY SOURCE

EXTENT OF INJURY

Completed By (type or print)	Signature & Title	Date (mm/dd/yy)

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

PRINT CLEAR

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
_____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
_____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ❑ Check if you agree to receive notices about your claim by email only. ❑ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____.
You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.*_____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
_____
16. Insurance Policy Number. *El número de la póliza de Seguro.*_____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/*Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*