Safety Responsibilities
MEDIC

Safety Program information for the Medic

The following information is for your specific position and is provided to help you understand your part in your Production's **Injury & Illness Prevention Program (IIPP)/Safety Program**.

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

Please DO NOT share Workers Comp forms with your Production Safety Representative, as they contain personal health information.

In addition to their Health and Safety responsibilities, 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 Injury and Illness reporting forms and procedures from your Production Coordinator or payroll company.
2. 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 Acknowledgment 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 **Injury and Illness Reporting Procedures** attached to this document. Call your Production Coordinator if you have any questions.
   c. 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.

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.

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.

Safety Responsibilities
MEDIC

For every injury or illness:

1. See that the following forms are completed:
   - ***Employer's Report of Occupational Injury or Illness (Form 5020)*** or local equivalent.
   - ***Accident Investigation Report (Form 9)***. (The form can be completed by Medic, Patient, Department Head or POC.)
   - ***Right of Refusal of Medical Aid Form (Form 16)*** if the patient refuses recommended treatment or transportation to the hospital.
2. Forward all completed forms to the **Production Office Coordinator**.

When to Call an Ambulance

If a Medic determines that a patient requires EMT assistance and/or transportation to the hospital by ambulance, the Medic should call 911 (or facility Emergency Number) immediately. If the patient refuses the additional medical attention, the patient can argue the case with the EMT's.

As always, any patient refusing medical treatment recommended by the Medic should be asked to sign **Form 16: Right of Refusal of Medical Aid.**

NOTE: This Production has a contract with Verisk 3E for Safety Data Sheets for chemical-containing products. If someone is exposed to a chemical-containing product, dial **(800) 451-8346** and give as much information about the product as possible. Verisk 3E will email or fax a copy of the Safety Data Sheet.

INJURY AND ILLNESS REPORTING PROCEDURES

ALL INJURIES TO CREW OR CAST MEMBERS MUST BE REPORTED TO THE PRODUCTION SAFETY REPRESENTATIVE.

Form 9: Accident Investigation Report should be completed for every injury or illness, no matter the severity.

Serious Incident Reporting Procedures:
A Serious Incident is an injury or illness that results in transportation by ambulance, visitation to the hospital by one or more employees, any treatments other than general first aid,*any near miss during stunts or special effects, any injury – even minor – to cast members or stunt performers, or any serious property/asset damage.

**An OSHA chart of treatment that is considered First Aid is attached.*

Please note: *These are SAFETY PROGRAM procedures. Workers Comp requires different documentation. Because sensitive personal medial information is often included, please DO NOT send Workers Comp forms or reports to the Production Safety Representative unless specifically requested.*

UPM:
- If the injury or illness meets the criteria for a serious incident, IMMEDIATELY notify your **Production Safety Representative**, who will make all necessary notifications.
- **Accident Investigation Report – Form 9.**
  - Every section of this form needs to be completed, including "Steps taken to prevent recurrence."
  - This form can be completed by the person having the most knowledge of the incident: Medic, Department Head, Production Office Coordinator, UPM. The Production Safety Representative will assist if requested.
- Some injuries and illnesses require timely **OSHA notification**. The Production Safety Representative will make this notification, based upon information from you.
- **Forward completed Form 9 to POC.**

MEDIC:
- **IMMEDIATELY notify the UPM of the injury or illness.**
- Fill out ***Employer's Report of Occupational Injury or Illness (Form 5020)*** or local equivalent.
- If employee refuses recommended treatment or transportation to the hospital, have employee complete and sign ***Right of Refusal of Medical Aid – Form 16.***
- **Forward completed Form 5020 and Form 16 to Production Office Coordinator.**

POC:
- **Forward completed Form 9 and Form 16 to Production Safety Representative.**
- Forward Form 5020 if requested by Production Safety Representative.
- If patient is hospitalized, keep Production Safety Representative updated on status.

PRODUCTION SAFETY REPRESENTATIVE:
- Will notify OSHA if required.
- Will conduct additional investigation if needed.
- Will assist with any OSHA or other agency investigations.

First Aid List

1904.7 (b)(5)(ii) What is “first aid”?

For the purposes of Part 1904, "first aid" means the following:

(A)	Using a nonprescription medication at nonprescription strength (for medications available in both prescription and non-prescription form, a recommendation by a physician or other licensed health care professional to use a non-prescription medication at prescription strength is considered medical treatment for recordkeeping purposes);
(B)	Administering tetanus immunizations (other immunizations, such as Hepatitis B vaccine or rabies vaccine, are considered medical treatment);
(C)	Cleaning, flushing or soaking wounds on the surface of the skin;
(D)	Using wound coverings such as bandages, Band-Aids™, gauze pads, etc.; or using butterfly bandages or Steri-Strips™ (other wound closing devices such as sutures, staples, etc. are considered medical treatment);
(E)	Using hot or cold therapy;
(F)	Using any non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc. (devices with rigid stays or other systems designed to immobilize parts of the body are considered medical treatment for recordkeeping purposes);
(G)	Using temporary immobilization devices while transporting an accident victim (e.g., splints, slings, neck collars, back boards, etc.).
(H)	Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister;
(I)	Using eye patches;
(J)	Removing foreign bodies from the eye using only irrigation or a cotton swab;
(K)	Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means;
(L)	Using finger guards;
(M)	Using massages (physical therapy or chiropractic treatment are considered medical treatment for recordkeeping purposes); or
(N)	Drinking fluids for relief of heat stress.

(iii) Are any other procedures included in first aid?

No, this is a complete list of all treatments considered first aid for Part 1904 purposes.

ACCIDENT INVESTIGATION REPORT

(Send to Production Office Coordinator when completed.)

To be completed for EVERY injury or illness, regardless of severity.
For serious injuries or illnesses, see Form 4: Serious Incident Reporting Procedures.

EMAIL OR FAX (818) 954-2805 TO PRODUCTION SAFETY REPRESENTATIVE WITHIN 24 HOURS OF ACCIDENT

PRODUCTION NAME: _____ **DATE: _____**

INJURED'S NAME: _____ **TITLE: _____**

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:**

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.