ON-SITE
HEALTH & SAFETY

IN CASE OF INJURY

FOR ALL **LIFE THREATENING** INJURIES CALL **911**

LIFE THREATENING INJURIES ARE THOSE THAT INVOLVE:

- **LOSS OF CONSCIOUSNESS**
- **AIRWAY COMPROMISE**
- **BREATHING DIFFICULTY**
- **CIRCULATORY COMPROMISE**
- **OBVIOUS LONGBONE FRACTURES**
- **POSSIBILITY OF TRAUMATIC NECK OR BACK INJURY**
- **LARGE BURNS**
- **BURNS THAT INVOLVE THE FACE OR GENITAL AREA**

ALL OTHER INJURIES:

ON-SITE HEALTH & SAFETY

RESPONSE DIRECTLY TO YOUR WORKSITE

24 HOURS / 7 DAYS

866-998-2750

ALTERNATE AFTER-HOURS PHONE NUMBERS:

MOBILE: 925-525-9855 | 925-525-9851

Emergency Action Plan

1: **Minor Injury:**

Report to your supervisor any injury no matter how slight. If you or you supervisor feel that medical attention is needed, you should report to the Operations Manager in order to obtain authorization for medical treatment. For emergency treatment go to : San Francisco General Hospital 1001 Potrero Avenue (between 22nd and 23rd Streets)
San Francisco, CA 94110 For Minor Injuries Call: *Onsite Health and Safety (510) 245-2700*

2: **Serious Injury or Major Accident:**

Notify the Operations Manager immediately. The Operations Manager in conjunction with the supervisor will make arrangement for medical attention. If Medical attention needs to be brought to the site, the supervisor must appoint several workers to serve in the following capacities:

A: **Traffic directors for emergency vehicles**

B: **Crowd Control. (If you are not involved in the emergency, you do not need to be around the area)**

C: **Securing the area (This would include taping off the area and ensuring that the scene is kept intact)**

D: **Direct all information inquiries to the Operations Manager.**

3: **Fire or Earthquake:**

The main thing in any fire or earthquake is to keep a clear mind and to think before you act. The following guidelines should assist you in this effort. The supervisor needs to take control

A: **If the fire is small and in its beginning stage, extinguish it with the appropriate fire-fighting device.**

B: **If the fire is to big or is spreading faster than it can be extinguished, evacuate to the employee accountability area, call for fire assistance (911) and take a head count to ensure all workers are accounted for.**

I: **Direct workers to act as traffic control in order to get emergency vehicles to the proper area.**

II: **Keep all non-essential people away from area.**

C: **If a major earthquake strikes follow the same guidelines for fire. Try to position yourself near a stable structure. Do not try to run. After the shaking, proceed to the employee accountability area, and determine if all employees are accounted for.**

STAFF EMPLOYEE ACCOUNTABILITY AREA IS LOCATED: Out Front, just north at gate of empty lot.

REFUSAL OF MEDICAL TREATMENT FORM

EMPLOYER NAME: BLACK POINT PRODUCTIONS

PHONE: 415-726-9090

Today's Date / Fecha de hoy_____

Employee / Empleado_____

Social Security / Seguro Social_____

Department / Departamento_____

Date of Injury / Fecha de Lastimadura_____Time / Hora_____

Date employer first knew of injury / Fecha que patron supo de lastimadura _____
Time / Hora _____

Describe injury and part of body affected / Describa la lesion y la parte del cuerpo afectada

_____

NOTIFICATION DE LASTIMADURA Y REHUSAR CUIDADO MEDICO

A mi _____me ha dado mi patron, la oportunidad de recibir atencion medica para la lastimadura supracirada. En este momento, no creo necesitar atencion medica. Sin embargo, si llego necesitar tal atencion me reportare inmediatamente a la oficina de la compania. Entiendo que esta es mi obligacion bajo el codigo laboral de California.

El que yo firme esta declaracion es solo en reconocimiento que se me ha dado la oportunidad de ser examinado y de recibir tratamiento y no estoy renunciando a mis derechos bajo las leyes de compensacion de tabajadores. Ademas, reconozco que he recibido la forma DWC-1 las cual protege mis derechos.

NOTICE OF INJURY & REFUSAL OF MEDICAL CARE

I,_____have been offered the opportunity to have medical care for the above stated injury by my employer. I feel as though I do not require medical care at this time. However, should I feel the need to have care I will immediately report to my employer's office to request medical care. I understand this is my obligation under the California Labor Code 4600.

My signing of this statement only acknowledges that I have been given the opportunity to be examined and treated and in no way waves my right under worker's compensation laws. I also acknowledge that I have been given a claim form DWC-1 which protects my rights.

_____ _____
Employee's Signature / Firma de empleado Date / Fecha

_____ _____
Supervisor's or Foreman's signature / Firma de supervisor o mayordomo Date / Fecha

_____ _____
Witness Signature or Name / Firma or nombre de testigo Date / Fecha

THEATRICAL STAGE EMPLOYEES LOCAL #16 I.A.T.S.E.
240 Second St. San Francisco, CA 94105
Office: 415-441-6400
Fax: 415-243-0179

ACCIDENT REPORT FORM

I.A.T.S.E. JOB #:

DATE OF INCIDENT: / / 20

NAME:

PHONE:

EMPLOYER: Black Point Productions

PAYROLL CO: Black Point Productions Inc

WORKERS COMP INSURANCE COMPANY: State Fund Comp

POLICY # xxx5144

CO. REPRESENTATIVE:

JOB NAME:

JOB DATES:

VENUE:

STEWARD:

HOURS WORKED BEFORE INCIDENT:

HOURS WORKED AFTER (IF ANY): 54

PLEASE DESCRIBE THE DETAILS OF THE INCIDENT:

(PLEASE USE ADDITIONAL PAGES IF NECESSARY)

ACCIDENT REPORT FORM

(continued)

FOLLOW -UP CONTACT PERSON: _____

PHONE NUMBER: _____

OTHER APPLICABLE INFORMATION: _____

_____

_____

_____

NOTE: THIS FORM IS FOR EMPLOYER AND UNION STAFF USE ONLY. THIS FORM IS NOT INTENDED FOR NOR DOES IT REPLACE THE ACTUAL INSURANCE ACCIDENT REPORT NOR ANY FACILITY REQUIRED REPORTS OR INSURANCE FORMS. PLEASE FILL OUT ALL APPROPRIATE INSURANCE FORMS AS SOON AS POSSIBLE.

DO NOT FILL OUT THIS SECTION - OFFICE USE ONLY

RESOLUTION:

BLACK POINT PRODUCTIONS, INC.

Employee Accident/Incident Report

Directions: *This form should be completed in its entirety by the injured or ill employee within 24 hours of an incident to document the events of the accident or illness.*

GENERAL INFORMATION

Employee Name	*Social Security #*	*Job position/title*
Date of Accident/Illness/Incident	*Day of Week* ☐Mon. ☐Tues. ☐Weds. ☐Thurs. ☐Fri. ☐Sat. ☐Sun.	*Exact Time of Day* AM PM
Specific Job Performed When Incident Occurred	*Exact Location of Incident*	
Date and Time Reported	*Reported to Whom*	

ACCIDENT INFORMATION

☐ Employee	☐ Reported to OSHA	☐ Medical Treatment Only
☐ Non-Employee	☐ Fatality	☐ First Aid Only
☐ Vehicle	☐ Amputation	☐ No Injury, No Damage
☐ Property – Fire, Theft, Flood	☐ Hospitalization	☐ Other:

DESCRIPTION OF INJURY/ILLNESS/INCIDENT

In each section below, check & circle all the items that best describes the injury or illness

Nature of Injury/Illness			Part of Body Affected		
☐ Abrasion	☐ Dermatitis	☐ Shock or electrical	☐ Abdomen	☐ Foot R/L	☐ Mouth
☐ Amputation	☐ Emotional	☐ Sprain or strain	☐ Arm R/L	☐ Hand R/L	☐ Toe
☐ Bruise or contusion	☐ Fracture	☐ Visual	☐ Back	☐ Head	☐ Wrist R/L
☐ Crushing injury	☐ Hearing	☐ Multiple	☐ Chest/Shoulder	☐ Internal	☐ Multiple
☐ Cumulative trauma	☐ Hernia	☐ Other	☐ Ear R/L	☐ Leg R/L	☐ Other
☐ Cut or puncture	☐ Occupational Illness		☐ Eye R/L	☐ Neck	☐ Right Dominant
			☐ Finger	☐ Nose	☐ Left Dominant

Was medical treatment provided at the scene? ☐ Yes ☐ No	*If "Yes" describe what treatment was provided and by whom:*
Did you go elsewhere for medical treatment? ☐ Yes ☐ No	*If so, where and by whom*

1. What Happened? Describe what and how the accident/incident occurred:

BLACK POINT PRODUCTIONS, INC.

2. Why did it happen? Develop the cause of the accident/incident. Focus on contributing factors: people, material, equipment:
3. Where did it occur? Be specific:

Witness Information: *List each witness and his or her phone number below. Also attach his or her statement to this form.*

Name	Phone Number	Name	Phone Number

Could anything be done to prevent accidents of this type? If so, What?
Additional Notes:

Employee Signature	*Date*	*Supervisors Signature*	*Date*

ACCIDENT/EXPOSURE INVESTIGATION REPORT

Date & Time of Accident:

Location:

Accident Description:

Workers Involved:

Witnesses:

Preventive Action Recommendations:

Corrective Actions Taken:

Manager Responsible: **Date Completed:**

BLACK POINT PRODUCTIONS, INC.