



Right of Refusal of Medical Aid

PRODUCTION/EVENT COMPANY _____

PROJECT/EVENT TITLE _____

This form has been given to you because you have refused or declined an initial offer of treatment or transportation for medical treatment to a health provider.

I, _____ hereby refuse the first aid treatment or transportation for medical treatment to a health provider for the illness or injury incurred by me on this date _____.

In signing this waiver, I relieve the production/event company and Cast & Crew/CAPS from any and all liability or damages resulting from this refusal to accept such first aid treatment.

Employee Name (Print or Type)

Job Title or Position

Employee Signature

Date

Supervisor Signature

Supervisor Name (printed)

Medic Signature

Medic Name (printed)

Should your condition require further medical treatment, please contact Cast & Crew immediately at workcomp@castandcrew.com. Please submit via email or fax the completed copy of this form to Cast & Crew within 24 hours of knowledge of injury.

Cast & Crew Entertainment Services, LLC- Workers' Compensation Department
Tel: 818.848.6022 Fax: 818.848.4614 workcomp@castandcrew.com

2300 Empire Avenue 5th Floor Burbank California 91504 T 818.848.6022 www.castandcrew.com

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