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: PAYROLL CO:

WORKERS COMP INSURANCE COMPANY:

POLICY # CO. REPRESENTATIVE:

JOB NAME: JOB DATES:

VENUE: STEWARD:

HOURS WORKED BEFORE INCIDENT: HOURS WORKED AFTER (IF ANY):

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: