

**Accident Report of Workers' Compensation Claim**

**Instructions**

All sections must be completed within 24 hours of injury or illness before claim can be filed. To be eligible for benefits under the Workers' Compensation Act, VCU Employee Health Services must receive both this completed claim form (P-100) and the Physician Selection Form (P-101) by hand delivery or by mail:

* Email to: workcomp@vcu.edu or
* Deliver or mail to: VCU Employee Health, 1200 East Broad Street, West Hospital, West Wing, First Floor, Room 120, Box 980134, Richmond, VA 23298-0134.

**Employee section: Complete, sign and return**

Name (first, last, middle):

DOB:

Gender: [ ] M [ ] F

Marital Status: [ ] S [ ] M [ ] W [ ] D

Home Address (street, city, zip code):

Home Phone:

Work Phone:

Cell Phone:

V-ID# (contact your Personnel Administrator for your V-ID#):

VCU Hire Date:

Department:

Dept. Box #:

Employee Type: [ ] Faculty/Staff [ ] Hourly [ ] Other

Hours Worked:       Daily       Weekly       Shift

Job Title:

Address where injury occurred (e.g., 1101 East Marshall St., Sanger Hall, R. 1-032):

Date of injury:

Time of injury:       [ ] AM [ ] PM

Describe activity prior to accident and type of accident (*attach additional sheet if necessary*):

Cause and object of injury (describe in detail how and why injury occurred. If by needle stick, give patient’s name and chart #):

Injuries sustained:

Have you claimed a WC claim(s) in the past? [ ] Yes [ ] No If “yes”, list date(s):

I certify that the information provided above is true and complete. (May be signed by person acting on employee’s behalf)

Signature:

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|  |

Date:

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**Supervisor section:
Complete, sign and send to EHS. If you DO NOT agree with the employee’s report, please contact the VCU WC Office at 828-1533. For assistance in accident investigation/prevention, please contact the VCU Occupational Safety Office at (804) 828-0040.**

Was the employee doing something other than required duties at the time of the accident? [ ] Yes [ ] No If “yes”, please explain:

When did you first learn of the accident?

Was the employee given medical treatment? [ ] Yes [ ] No If “yes”, physician’s name and address:

Was the accident on VCU premise? [ ] Yes [ ] No If “no”, please explain:

Based on your investigation, what was (were) the cause(s) of the accident? (*attach additional sheet if necessary*):

How could this accident have been prevented? (e.g., wear protective equipment, equipment should have been repaired, etc.):

What were the steps taken to prevent another accident? (e.g. Housekeeping contacted, training provided, etc.):

Supervisor’s name:       Box Number:       Work Phone:

Signature:

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|  |

Date:

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Medical personnel section:
Complete, sign and return to VCU Human Resources.

Date Seen:       Time Seen:       [ ] AM [ ] PM By whom?

Facility Address:

Diagnosis:

Was the diagnosis related casually to the accident? [ ] Yes [ ] No If “yes”, please explain:

Lost Time? [ ] Yes [ ] No If “yes”, dates:       Probable length of disability?

Return to duty? [ ] Yes [ ] No If “yes”, dates:       [ ] Regular duty [ ] Light duty

Explain duty restrictions:

Referral? [ ] Yes [ ] No If “yes”, where?       When? [ ]

Follow-up? [ ] Yes [ ] No If “yes”, where?       When?

Completed by:       Date:       OSHA Case #: