Virginia Commonwealth University

Accident Report of Workers' Compensation Claim

Complete *all* sections *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:

- *Deliver* to: VCU Employee Health Services, 1200 East Broad Street, West Hospital, West Wing, First Floor, Room 120
- *Mail* to: VCU Employee Health Services, P. O. Box 980134, Richmond, VA 23298-0134

EMPLOYEE SECTION – Complete, sign and give to supervisor.

Name: _____ DOB: _____ ☐ M ☐ F ☐S ☐W ☐M ☐D
(last, first, middle) *(Gender)* *(Marital Status)*

V-ID#: _____ VCU Hire Date: _____ Home Address: _____
[contact your Personnel Administrator for your V-ID #] *(street, city, zip code)*

Home Phone: ( ) _____ Department: _____ Dept. P.O. Box #: _____

Work Phone: ( ) _____ ☐Faculty/Staff ☐Hourly ☐Other Hours Worked: _____ _____ _____
Cell Phone: ( ) _____ *(Employee Type)* *Daily* *Weekly* *Shift*
Email: _____

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 filed a WC claim(s) in the past? ☐Yes ☐No If "yes," list date(s): _____

Name(s) of any witness(es): _____

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

Signature: _____ Date:

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 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 this accident? _____

Was the employee given medical treatment? ☐Yes ☐No If "yes," physician's name and address: _____

Was the place of the accident on VCU premises? ☐Yes ☐No If "no," please explain: _____

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

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

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

Supervisor's Name: _____ P.O. Box #: _____ Work Phone: _____
(please print)

Signature: _____ Date: _____

MEDICAL PERSONNEL SECTION – Complete, sign and forward to WC Office.

Date Seen: _____ Time Seen: _____ AM/PM By Whom? _____

Facility Address: _____

Diagnosis: _____

Was the diagnosis related causally 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 #: _____