

Please provide the following information as soon possible as it relates to your work related

accident/injury/illness preferably within **24 hours**. Call and send this completed form to: Libby or Eric

Phone : **804-684-7201, Libby MacDonald or 804-684-7322 Eric Fidler**. You are required to select from a panel of medical specialists for medical treatment as mandated by the Virginia's Workers' Compensation Act.

Employee Information

| | | | |
|--------------------|-----------------|------------------|--------------------------|
| Name | | SSN | |
| Address | | Cell Phone | |
| City | | Home Phone | |
| State | | Work Phone | |
| Zip Code | Marital Status: | Single | Married Divorced Widowed |
| Date of Hire | Date of Birth | Sex: | Male Female |
| Occupation | | Department | |
| Work Hours Per day | Days per week | Time work begins | |
| Emp Type: | Hourly | Classified | University Faculty Other |

Information About Time/Place of Accident

| | | | |
|--|------------------|--------------------------|--------|
| City or County where this accident occurred : | | | |
| Exact Location : | | | |
| Date of Accident : | Time of Accident | AM | PM |
| Date accident reported : | | | |
| Were you paid in full for the day of the accident? | | | Yes No |
| Supervisor's Name | | Was supervisor notified? | Yes No |
| Name of Witness(es): | | | |

Information About the Nature and Cause of Accident

| | | | |
|---|--------|-------------------|------|
| Machine, tool or object causing injury | | | |
| Was safety equipment used? | Yes No | If so, what kind? | |
| Describe fully how injury occurred : | | | |
| Describe nature of Injury and describe body part affected (to include right or left side) : | | | |
| Was medical treatment provided? | Yes No | Where | |
| Was time lost from work? | Yes No | If yes, how long? | |
| Date returned to work | | | |
| Could this accident have been avoided? | Yes No | If yes, how? | |
| Employee Signature | | | Date |
| Supervisor Signature | | | Date |