

# 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  
(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 Hrs Worked: \_\_\_\_\_  
(Employee Type) Daily Weekly Shift

Job Title: \_\_\_\_\_ Location Where Injury Occurred: \_\_\_\_\_  
(e.g., Sanger Hall, R. 1-032)

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_ AM/PM Day of Week: \_\_\_\_\_

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 #: \_\_\_\_\_