

**Employer’s First Report of Accident** (P-100)

**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 Human Resources, Workers Compensation must receive this completed claim form (P-100) and the Physician Selection Form (P-101):

* Email to: [workcomp@vcu.edu](mailto:workcomp@vcu.edu) or
* Deliver or mail to: VCU Employee Health, 1200 East Broad Street, West Hospital, West Wing, First Floor, Room 120, and Box 980134, Richmond, VA 23298-0134.
* If you have already received medical treatment related to this accident, please include a copy of the medical notes from your physician visit when returning this form.

**PART A: TO BE COMPLETED BY EMPLOYEE (Answer all questions completely)**

**If you need assistance in completing this form, consult with your supervisor, your department’s HR Professional, and/or VCU HR Workers’ Compensation (**[**workcomp@vcu.edu**](mailto:workcomp@vcu.edu) **or 804-828-1533).**

|  |  |  |
| --- | --- | --- |
| 1. Name (Last, First, Middle):  Enter here | | 2. V-ID#: Enter here  2a. Email: Enter here  3. Preferred language: Enter here |
| 4. Home Address:  Street Address: Enter here Apartment: Enter here  City: Enter here State: Enter here Zip Code; Enter here | | 5. Phone numbers:  Home: Enter here  Work: Enter here  Mobile: Enter here |
| 6a. Marital Status (check one): Single  Married  Divorced  Widowed  6b. Sex (check one): Male  Female | | 7. Date of Birth (MM/DD/YYYY):  Enter here |
| 8a: Occupation at the time of accident (job title)  Enter job title  8b. Department  Enter department name | 8c. Immediate Supervisor:  Enter supervisor name  8d. Employee Type (check one):  Salaried Faculty/Staff  Hourly/Wage  Other | |
| 9a. Start date in current position:  Enter start date  9b. Time started working on day of injury:  Enter time | 9c. Hours worked per day Enter here  9d. Days worked per week: Enter here | |
| 10a. Date of Accident:  Enter date  10b. Time of Accident:  Enter time | 10c. Date you became incapacitated:  Enter date or N/A  10d. Hour you became incapacitated:  Enter hour (AM or PM) or N/A | |
| 11: Date Accident Reported:  Enter date | 12: Supervisor or authority to whom accident reported:  Enter name | |

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13. Fully describe the area and conditions where the accident occurred (include address and location).

Begin typing here

14. Who else was involved in the accident, or was a witness to the accident?

Begin typing here

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| 15a. Machine, tool, or object causing injury or illness (e.g. machine, ladder, loose brick, stairs, etc.)  Enter information here |
| 15b. What safeguards were provided (e.g. protective equipment, machine guard, etc.)?  Enter information here |
| 15c. Were safeguards in use at the time of the accident? (check one) Yes  No  N/A |
| 15d. If not, please explain:  Begin typing here |

16. Describe in detail the activity immediately prior to the accident:

Begin typing here

17. Describe in detail how the accident happened (attach additional pages if necessary):

Begin typing here

18. Describe the nature of injury or illness, including specific body parts affected:

Begin typing here

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| --- |
| 19. Was on-site minor first aid administered to you? (check one) Yes  No |
| 20. Were Campus Police notified? (check one) Yes  No  If yes, enter Police Report number: Enter report number |
| 21. Do you need to seek medical treatment? (check one) Yes  No  Note: Treatment must be provided or authorized by an approved panel physician. The panel of physicians is offered on the Physician Selection Form available at <https://hr.vcu.edu/current-employees/benefits/a-z-list-of-benefits/workers-compensation/> or by calling VCU Human Resources Workers’ Compensation at (804) 828-1533***. Cases requiring immediate attention may proceed to the closest emergency facility.*** |
| 22a. Do you believe you require temporary modified duties? (check one) Yes  No |
| 22b. If you have already received treatment, will additional medical treatment by a physician be necessary? Yes  No  N/A |
| 23a. Have you returned to work? (check one) Yes  No |
| 23b. If answer to 23a is yes, date of return: Enter date (MM/DD/YYYY) |
| 23c. If answer to 23a is no, how long do you expect to be unable to work? (based on your physician’s estimate):  Enter information here |

Comments:

Begin typing here

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| --- | --- | --- | --- |
| I certify that the information provided above is true and complete. | | | |
| EMPLOYEE’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | DATE: Enter date |
| Prepared by: Enter information here | Date: Enter date | Phone No. Enter phone | |

**PART B: TO BE COMPLETED BY SUPERVISOR**

**Complete, sign and send to Employee Health Services (see page 1) or** [**workcomp@vcu.edu**](mailto:workcomp@vcu.edu)**. If you DO NOT agree with the employee’s report, please contact the VCU Human Resources Workers’ Compensation Office at (804) 828-1533 or** [**workcomp@vcu.edu**](mailto:workcomp@vcu.edu)**. For assistance in accident investigation/prevention, please contact the VCU Occupational Safety Office at (804) 827-0357.**

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| --- | --- |
| Employee’s Name:  Enter employee’s name | Date of injury/illness:  Enter date (MM/DD/YYYY) |

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| --- |
| 1a. Date when you first knew of the accident: Enter date (MM/DD/YYYY) |
| 1b. By whom were you first notified? Enter information here |
| 2a. Do you concur with the employee’s statements in Part A? (check one) Yes  No |
| 2b. If the answer to 2a is no, please explain any discrepancies:  Begin typing here |
| 3a. Was the injury/illness job related ? (check one) Yes  No |
| 3b. Did accident occur during employee’s normal job duties? (check one) Yes  No |
| 3c. Did accident occur on property owned/maintained by the university? (check one) Yes  No  Not sure |
| 4a. Was the employee on duty? (check one) Yes  No |
| 4b. If the answer to 4a is no, was the employee on employer premises as a condition of employment? Yes  No |
| 4c. If the answer to 4a is no, was the employee on employer premises as member of the general public? Yes  No |
| 4d. If the injury/illness occurred off employer premises, was employee present as a condition of employment, or in travel status and engaged in work or travel function? Yes  No |
| 5a. Was safety equipment or regulation(s) established at the time of accident/illness? Yes  No  N/A |
| 5b. Was employee aware of safety equipment or regulation(s) at time of accident/illness? Yes  No  N/A |
| 5c. Was the safety equipment or regulation(s) in use at the time of accident/illness? Yes  No  N/A |
| 5d. Was the accident caused by employee’s failure to use safety equipment or observe regulation(s)?  Yes  No  N/A |
| If the answer to 5d is yes, please explain:  Begin typing here |
| 6. How could the injury/illness have been prevented?  Begin typing here |
| 7. What precautions have been taken to prevent future accidents of this nature?  Begin typing here |
| 8. Supervisor(s) who should be notified of employee’s schedule and/or job modifications (list name and contact information): Begin typing here |
| Additional comments, if any: Begin typing here |
| **Supervisor’s Signature and Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** Date |

**PART C: TO BE COMPLETED BY MEDICAL PERSONNEL**

**Please complete, sign, and return to VCU Human Resources Workers’ Compensation (**[**workcomp@vcu.edu**](mailto:workcomp@vcu.edu) **or fax to 804-827-4635)**

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| --- | --- | --- | --- |
| **Employee Name:**  Enter employee’s name | | **Date of injury/illness:**  Enter date (MM/DD/YYYY) | |
| Date seen: MM/DD/YYYY | Time seen: Time A.M.  P.M. | | By whom? Provider name |
| Facility address:  Street Address: Street Address  City: City State: State Zip Code: Zip Code  Office phone: Office phone | | | |
| Diagnosis:  Begin typing here | | | |
| Was the diagnosis related causally to the accident? Yes  No  If yes, please explain:  Begin typing here | | | |
| Lost time? Yes  No  If yes, please enter dates: Enter date(s)/date range here  Probable length of disability: Enter probably length of disability here | | | |
| Return to duty? Yes  No  If yes, dates for: Regular Duty: MM./DD/YYYY Light Duty: MM/DD/YYYY or N/A | | | |
| If light duty, explain duty restrictions:  Begin typing here | | | |
| Referral? Yes  No  If yes, where and when? Begin typing here | | | |
| Follow up? Yes  No  If yes, where and when? Begin typing here | | | |
| **Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Date** | | | |

Virginia Commonwealth University

Human Resources – Workers’ Compensation

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