



University of Virginia Medical Center
Accident Report for Workers Compensation Claim

This form must be completed and returned to Employee Health within 48 hours of the incident - 1222JPA, First Floor, Telephone Number 434-924-2013 or email to employeehealth@virginia.edu

If the employee is evaluated for a work-related incident in the ED, they must contact Employee Health on the next business day to ensure required documentation has been received. 434-924-2013 or employeehealth@virginia.edu

Injured Employee

Form fields for Injured Employee: First Name, MI, Last Name, Employee ID #, Home Address, Street, City, State & Zip Code, Date of Birth, Cell Phone, Work Phone, Job Title, Department of Employment

Injury OR Occupational Illness

Form fields for Injury OR Occupational Illness: Date of Incident, Time, Exact Location, #Hours worked before Incident, Consecutive days worked prior to Incident, Reported incident to (Supervisor), Date, Time, Type of Incident, Blood/body Fluid Exposure, Lifting equipment used, Nature of Injury, Describe in detail what you were doing just before the incident and how the accident occurred

Employee Signature Work Phone#

Employee's Signature, Date Signed

Falsification of records is a serious misconduct, which may result in discharge.

Witness

Form fields for Witness: First, MI, Last Name, Job Title, Phone Number

Supervisor In Charge At Time Of Incident

Form fields for Supervisor In Charge: Submit this form within 48 hours to Employee Health. Please see submitting information at the top of this form. Was the employee doing something other than required duties at the time of the accident? If yes, please explain: Give accident cause, and comment fully: What action are you taking to prevent recurrence of this type of incident? Was the employee given medical treatment? Has the injured employee returned to work? Supervisor's Signature: Work Address, Phone#: