University of Virginia Agency 207 (ACD) Accident Report for Workers' Compensation Claim

Both the injured employee and their supervisor should legibly complete this form.

The Accident Report Form, Physicians Panel, and any documentation from initial medical attention should be emailed to leave@virginia.edu *within 7 calendar days of the date of injury* to promote timely claim decision for the injured employee and to ensure the University is in compliance with the Workers Compensation Commission requirements.

In the subject line of the email, indicate "[workers' comp] New Claim Request."

Employee Information

Name: _____ Date of Birth: _____

Home Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Communication (please select one): __ Work Phone __ Home Phone __ Cell Phone __ Email

Computing ID/email address_____ Department:_____

Occupation: _____ # of Hours Worked per Day (not including overtime): _____

Information Regarding Time & Place of Injury

Date of Accident: _____ Time: _____ AM or PM Time shift began_____ AM or PM

Exact Location of Accident (including zip code): _____

Date Accident Reported: _____ Reported Accident to: _____

Supervisor Notified (please check): Yes ____ No ____ Supervisor Name: _____

Name & Contact Info of Witness(es)

_____

_____

_____

If the injured employee usually enters hours worked, the injured employee or supervisor should enter Regular Time worked in Workday for the entire shift on the date of injury.
Note: Exempt employees that do not usually enter hours in Workday do not need to take any action. Do not enter leave or time off in Workday for the date of the injury.

Information Regarding the Nature & Cause of Accident

Cause of Injury: _____

Nature of Injury (broken bone, strain, burn, etc): _____

Parts of body affected (indicate 'right' or 'left'): _____

Machine, tool, or object causing injury: _____

Specify part of machine: _____

Was safety equipment used: Yes ___ No___ If so, what kind: _____

Describe Activity Prior to Accident and Type of Accident (Please be as specific as possible): _____

_____

_____

_____

_____

_____

_____

_____

Was Medical Treatment Provided: Yes ___ No ___ Where: _____

Was time lost from work: Yes ___ No ___ If yes, dates & amount of time lost: _____

_____

Date Returned to Work: _____

Falsification of records is considered serious misconduct and may result in discharge.
I certify the above information is true and complete.

Employee Signature: _____ Date: _____

Supervisor in Charge at the Time of Accident

For assistance in accident investigation/prevention, please contact the Office of Environmental Health and Safety at 434-982-4911. Assistance will be promptly provided.

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 the accident: _____

Did the accident occur on UVA owned &/or maintained property: Yes ____ No ____

Did a non-University person contribute to the accident: Yes ____ No ____ If yes, please explain: _____

_____

_____

Give accident causes and comment fully (Please be as specific as possible): _____

_____

_____

_____

_____

_____

Supervisors play an important role in providing safe work environments. How could this accident have been prevented?

_____

_____

_____

_____

What were the steps taken to prevent another accident? (ex. housekeeping contacted, training provided, etc.)

_____

_____

_____

_____

Supervisor's Printed Name: _____

Supervisor's Signature: _____ Date: _____

Work Phone Number: _____ Work Email: _____

Please attach any additional documentation or information.

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Workers' Compensation Physician Panel for UVA Academic Division Employees

The University of Virginia is offering the following Attending Physician Panel in compliance with Section 65.2 of the Virginia Workers' Compensation Act. The below panel is to be used by employees in the University's Academic Division (Agency 207).

Injured Academic Division employees who have filed for Workers' Compensation benefits must choose one physician for treatment of claimed, work-related injuries. Failure to choose one of the physicians listed below may bar compensation benefits, including the cost of medical care.

Employees' Primary Care Physicians are *NOT* authorized as attending physicians on UVA's Panel.

Panel of Physicians

Dr. Daniel Chan (434) 978-3998
MedExpress
1149 Seminole Trail Charlottesville, VA 22901
https://www.medexpress.com/

Dr. Daniel Chan (434) 244-3027
MedExpress
260 Pantops Center Charlottesville, VA 22911
https://www.medexpress.com/

Dr. Denee J. Moore (434) 227-5624
Neighborhood Family Health Center
901 Preston Ave., Ste 301 Charlottesville, VA 22903
http://www.cvhsinc.org/locations/nfhc

Dr. David Rubendall (434) 243-0075
UVA - WorkMed
1910 Arlington Blvd., Charlottesville, VA 22903
https://uvahealth.com

Panel physicians will make appropriate referrals to specialists.

Emergency Facilities for Initial Emergency Visit Only

UVA University Hospital Emergency Room (434) 924-2231
1215 Lee Street, Charlottesville, VA 22903

Martha Jefferson Emergency Room (434) 654-7150
500 Martha Jefferson Drive, Charlottesville, VA 22911

I have been offered a choice of attending physicians from UVA's Workers' Compensation Panel and have chosen the following physician:_____
Employee Signature: _____ Date: _____
Print Employee Name: _____ Date of Accident: _____

Please initial _____I understand that I am responsible for any costs incurred if Workers' Compensation denies my claim. I understand that I am also responsible for obtaining prior authorization from MC Innovations for all referrals to specialists.

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