

## University of Virginia Agency 207 (ACD) Checklist for Workers' Compensation Claims

Employees should submit documentation for claims even if there is no lost time or medical expense involved.

- Indemnity (lost time)
- Medical Only
- Reporting Purposes Only

### Summary Steps:

Employee	Supervisor
1. Report the accident to your supervisor.	
2. Seek medical attention and locate a pharmacy, if required.	
3. Complete the accident report form and physician panel, and submit along with medical documentation to the Supervisor.	
4. Enter normal hours worked for the day of accident, if applicable.	
	5. Fill out the supervisor section of the accident report form.
6. Submit the accident report form, physician panel, and any documentation from initial medical attention to the UVA HR Leave team <b>within 7 calendar days of the date of injury</b> .	
7. Call the VSDP provider (Reed Group), if applicable.	
8. Submit documentation after each medical appointment to the UVA HR Leave team <i>and</i> cooperate with the nurse consultants and related return-to-work efforts, if applicable.	
9. Submit return-to-work release documentation to the UVA HR Leave team and your supervisor <b>prior to returning to work</b> .	

### Detailed Steps:

- 1. **Employee** Report the accident to your supervisor.
- 2. **Employee** Seek medical attention and locate a pharmacy, if required.

*Note: If your accident is an emergency, please seek medical treatment from the UVA Health System or Martha Jefferson emergency room. This is ONLY for the initial treatment.*

*Note: If the emergency department is not required, seek medical treatment from a [panel physician](#).*

*Note: Use a pharmacy card to prevent paying out-of-pocket for medications related to the injury. Visit the [First Fill Card site](#), enter passphrase (23219), and follow the template to download (print), email, fax, or text the card. The Alius Health network includes all major pharmacy chains, grocery stores, and many single location pharmacies. You must take the First Fill Card to a participating pharmacy.*

- 3. **Employee** Complete the [accident report form](#) and [physician panel](#). Submit both documents and any documentation from initial medical attention to your supervisor.

*Note: Facilities Management Employees should complete their department's [online form](#).*

*Note: All injured employees must complete the physician panel. If the Workers Compensation Commission requires a second opinion, the injured employee must have previously selected a physician from the panel for this later review. If an injured employee continues to see a physician not on the panel, it could impact the workers compensation claim decision or coverage.*

- **4. Employee or Supervisor** If the injured employee usually enters hours worked, 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.*

- **5. Supervisor** Fill out the supervisor section of the accident report form.

- **6. Employee or Supervisor** Submit the completed accident report form, physician panel, and any documentation from initial medical attention to [leave@virginia.edu](mailto:leave@virginia.edu) with the Subject: “[workers’ comp] New Claim Request.”

*Note: To promote timely claim decision for the injured employee and to ensure the University is in compliance with the Workers Compensation Commission requirements, full documentation should be submitted to UVA HR within **7** calendar days of the date of injury.*

- **7. Employee** If you are a VSDP (Virginia Sickness and Disability Program) participant and the work-related injury or disease is anticipated to exceed 7 calendar days of missed work, call the VSDP provider (Reed Group) to report at 1-877-928-7021. A short-term disability claim for a work-related injury must be initiated to the Reed Group within 14 days of the injury. Otherwise, any time missed prior to 14 days after the date of injury will not be covered under the short-term disability benefit.

- **8. Employee** Email [leave@virginia.edu](mailto:leave@virginia.edu) with the Subject: “REFERENCE NUMBER [workers’ comp] Additional Claim Documentation” after each medical appointment to provide outcome documentation and return-to-work status. You may also choose to alert your supervisor after each appointment. If a nurse is assigned, cooperate with the nurse consultants and related return-to-work efforts.

*Note: Reference Number is found on a reply email, example: [ ref:\_00A11abcd.\_1234A12b5CD:ref ]*

- **9. Employee** Upon receiving a return-to-work release, email the attachment to [leave@virginia.edu](mailto:leave@virginia.edu) and to **your supervisor** with Subject: “REFERENCE NUMBER [workers’ comp] Return-to-Work Release” **prior to returning to work.**

*Note: Reference Number is found on a reply email, example: [ ref:\_00A11abcd.\_1234A12b5CD:ref ]*

#### QUESTIONS?

<https://hr.virginia.edu/time/workers-compensation> | [leave@virginia.edu](mailto:leave@virginia.edu)

David Garono: [dag9hu@virginia.edu](mailto:dag9hu@virginia.edu) | 434-924-1426

## **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](mailto: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): \_\_\_\_\_

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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: \_\_\_\_\_

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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?

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

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Supervisor's Printed Name: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Work Email: \_\_\_\_\_

Please attach any additional documentation or information.

The Accident Report Form, Physicians Panel, and any documentation from initial medical attention should be emailed to [leave@virginia.edu](mailto:leave@virginia.edu) with Subject, "[workers' comp] New Claim Request," *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.

## 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.

The Accident Report Form, Physicians Panel, and any documentation from initial medical attention should be emailed to [leave@virginia.edu](mailto:leave@virginia.edu) with Subject, "[workers' comp] New Claim Request," ***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.