

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

Please legibly complete this form and email it, along with the Panel of Physicians Form, to AskHR@virginia.edu. In the subject line of the email, indicate [workers comp]. Before sending, also make sure your Supervisor has completed and signed page 2 of the Accident Report. The Panel of Physicians form is required and should accompany the accident report. You can find the Panel at:

(<https://hr.virginia.edu/sites/default/files/Forms%20Website/Benefits/Workers%20Comp%20Panel.pdf>).

Employee Information

Name: _____

Home Address: _____

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

Preferred Communication (please circle): Work Phone Home Phone Cell Phone Email

Date of Birth: _____ Computing ID: _____

Email Address: _____

Department: _____

Occupation: _____ # of Hours Worked per Day _____

Information Regarding Time/Place of Injury

Date of injury: _____ Time of injury: _____ AM or PM

When did your work shift begin on the date of the accident? _____ AM or PM

Where did the accident occur? _____

Date accident reported: _____ Reported accident to: _____

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

Name & Contact Info of Witness(es) _____

Information Regarding the Nature and Cause of Accident

Cause of Injury: _____

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

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 (attach additional sheet, if necessary)

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: _____

Employee Signature: _____ Date: _____

Falsification of records is considered serious misconduct and may result in discharge.

I certify the above information is true and complete.

Supervisor in Charge at the Time of Accident (Please complete)

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/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: _____

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: _____

Space Provided for Additional Information as Needed: _____

The complete Panel of Physicians Form must accompany the Accident Report.