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

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

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Injury OR Occupational Illness

Date of Incident | Time | Exact Location (e.g., Bldg. & Rm.#) Where Incident Happened

#Hours worked before Incident | Consecutive days worked prior to Incident

Reported incident to (Supervisor): | Date: | Time:

Type of Incident (e.g., fall, struck by, material, patient handling) _____

If Blood/body Fluid Exposure, please circle one: Sharps/Needlestick Blood/Body Fluid

If a patient handling injury, was lifting equipment used? YES_____ NO_____

If the answer was yes to the question above, what TYPE of equipment was used:_____

Nature of Injury (e.g., broken bone, burn, strain) _____ Parts of Body Involved _____

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

First | MI | Last Name | Job Title | Phone Number

Supervisor In Charge At Time Of Incident

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? No Yes

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? _____No _____Yes If yes, Give Physician's Name and Address: _____

Has the injured employee returned to work? _____No _____Yes If yes, **GIVE DATE RETURNED**:_____

Supervisor's Signature: _____ Work Address, Phone#: _____