WHAT TO DO IF THERE IS A WORKPLACE ACCIDENT

SUPERVISORS

☐ Complete the First Report of Accident/Injury Form (pdf), have the injured employee sign the Physicians Selection Form (pdf) and ensure employee has emergency medical treatment if necessary. Forms are located on the HR web page.

☐ FAX COMPLETED FORMS & any doctor notes to HR: 757 221 3156

☐ Investigate workplace accidents working with EHS. Take witness statements & document facts. The Accident Investigation Job Aid Form is found on the EHS web page.

☐ Respond to requests from MCI.

☐ The department & EHS create any work orders for repairs required if there is an unsafe area.

☐ Assist in accommodating restrictions whenever possible.

☐ Do NOT allow employees to work without a release to return to work (RTW) that MUST BE turned into HR.

EMPLOYEES

☐ Report ALL accidents no matter how small to your supervisor immediately.

☐ ALWAYS Sign the physician panel and if treatment is necessary visit the panel physician first.

☐ Contact the Reed Group if you have VSDP Disability Benefits 877-928-7021.

☐ Turn ALL notes from physician into HR.

☐ Participate in accident investigations.

☐ Respond to all questions and letters sent by the carrier or the Reed Group regarding your claim. If you need assistance contact HR for an appointment to help you.

☐ Contact HR and pay for healthcare premium or request to waive healthcare if you will go on LWOP for an entire pay period while waiting for claims to be approved.

☐ Turn ALL notes from physician regarding requests for accommodations or for your release to return to work into HR.
The College of William and Mary/Vims

Employee’s First Report of Accident/Injury Form

Please provide the Office of Human Resources the following information as soon as it relates to your work related accident/injury/illness within 24 hours. Send this completed form to Human Resources.

Phone: 757-221-3769 or fax: 757-221-7724. Your are required to select from a panel of medical specialists for medical treatment as mandated by the Virginia’s Workers’ Compensation Act.

<table>
<thead>
<tr>
<th>Employee Information</th>
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| Name
| SSN
| Address
| Cell Phone
| City
| Home Phone
| State
| Work Phone
| Zip Code
| Marital Status: Single ○ Married ○ Divorced ○ Widowed ○
| Date of Birth
| Sex: Male ○ Female
| Occupation
| Department
| Work Hours Per day
| Days per week
| Time work begins
| Emp Type: Hourly ○ Classified ○ University ○ Faculty ○ Other

Information About Time/Place of Accident

City or County where this accident occurred:

Exact Location:

Date of Accident:

Time of Accident ○ AM ○ PM

Date accident reported:

Were you paid in full for the day of the accident? ○ Yes ○ No

Supervisor’s Name

Was supervisor notified? ○ Yes ○ No

Name of Witness(es):

Information About the Nature and Cause of Accident

Machine, tool or object causing injury

Was safety equipment used? ○ Yes ○ No

If so, what kind?

Describe fully how injury occurred:

Describe nature of Injury and describe body part affected (to include right or left side):

Was medical treatment provided? ○ Yes ○ No

Where

Was time lost from work? ○ Yes ○ No

If yes, how long?

Date returned to work

Could this accident have been avoided? ○ Yes ○ No

If yes, how?

Employee Signature

Date

Supervisor Signature

Date

Rev 02/17
The Virginia Workers' Compensation law requires your employer to provide to you a Panel of at least three physicians. You must select a physician from this Panel to treat your work related injury. **If you do not use one of these physicians for your work related injury, you may be responsible for the cost of medical care.**

Please select a physician from this Panel, complete and sign this form and return it to your supervisor. The supervisor should immediately return this form to **M C INNOVATIONS (MCI)**

P.O Box 1140, Richmond, VA 23218-1140 Phone 804/649-2288 Fax 804/371-2556

E-mail COVimaging@yorkrsq.com

Please choose from the following list by writing the physician's name and signing the form. Return the form to your supervisor.

1) Dr. Jamey Burton/Riverside PC Center
   
   NAME
   5231 John Tyler Hwy
   ADDRESS
   Williamsburg, VA 23185
   PHONE
   757-220-8300

2) Dr. Campana/First Med of Williamsburg
   
   NAME
   312 2nd Street
   ADDRESS
   Williamsburg, VA 23185
   PHONE
   757-221-4141

3) Dr. E. Obie/MD Express
   
   NAME
   120 Monticello Ave,
   ADDRESS
   Williamsburg, VA 23185
   PHONE
   757-564-3627

**Employee**

By signing this form, I release all medical information to M C Innovations (MCI). All information will be considered confidential and used only in the matter of the workers' compensation claim.

I have been presented with a panel of at least three physicians and have selected:

Dr. ____________________________ to provide me with medical care for my work related injury.

☐ I am not seeking medical treatment

Printed: ____________________________ Date of Injury: __________

Signed: ____________________________ Date: __________

NAME

Agency Representative: ____________________________

Printed Name Signature Date

Revised 6/14
ACCIDENT INVESTIGATION FORM

This form is to be utilized as an aid to further investigate accidents/injuries, to establish a root cause of the event, and to identify actions to mitigate future occurrences. For further assistance, please contact the William & Mary Environment, Health and Safety Office.

Injured Employee Name: ___________________________  Job Title: ___________________________

(If an injury occurred)

Department: ___________________________  Incident Date/Time: ___________________________

Supervisor: ___________________________  Investigation Date: ___________________________

Summary of What Occurred:

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________

Attach a sketch and photographs as necessary.

Site Observations:

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Attach a narrative statement written by the injured person(s).

Witness Accounts:

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________
Other Information:


Causes of incident:

1. 

2. 

3. 

4. 

Were practical means of accident prevention employed?

Ensure all hazards are controlled and service/repair requests have been initiated if needed.

Follow-up actions taken/required (For completed actions, list the date completed and for future actions, list the estimated date of completion):


Lessons Learned:


Investigated by: ____________________________ Date: ____________________________