

Workers' Compensation Checklist

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) for ALL claims. Ensure employee has emergency medical treatment if necessary. Include best contact #. Forms are located on the HR web page.
- FAX COMPLETED FORMS & any doctor notes to HR: 757 221 3156
- Investigate ALL workplace accidents working with EHS. Take witness statements with contact numbers & document facts. Take a photo of the scene where the injury occurred same day. The Accident Investigation Job Aid Form is found on the EHS web page. Be specific as to what happened. Note if there are any defects with the area of injury.
- Respond to requests from MCI.
- The department & EHS create any work orders for repairs required if there is an unsafe/defective areas.
- Assist in accommodating restrictions whenever possible. At 90 Days if not Released to full duty contact HR
- 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 providing specific details regarding your injury, the body part injured and the exact location where the injury occurred
- ALWAYS Sign the Physician Panel and if treatment is necessary visit the panel physician first or ER in an emergency and make doctor appointments before/after work hours. Once selected the physician cannot change unless you are referred to a specialist. Use leave until claim is approved
- Contact the Reed Group if you have VSDP Disability Benefits 877-928-7021 and have lost time
- Turn ALL notes from physician into HR (Including Restrictions & Release to Return to Work)
- Participate in accident investigations
- Respond to ALL questions, phone calls and letters sent by the workers' comp administrator 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 if you have no leave

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 : **757-221-3169** or fax: **757-221-3156**. You are required to select from a panel of medical specialists for medical treatment as mandated by the Virginia's Workers' Compensation Act.

Employee Information

Name		SSN	
Address		Cell Phone	
City		Home Phone	
State		Work Phone	
Zip Code	Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/>		
Date of Birth	Sex: <input type="radio"/> Male <input type="radio"/> Female		
Occupation	Department		
Work Hours Per day	Days per week	Time work begins	
Emp Type: <input type="radio"/> Hourly <input type="radio"/> Classified <input type="radio"/> University <input type="radio"/> Faculty <input type="radio"/> Other			

Information About Time/Place of Accident

City or County where this accident occurred :			
Exact Location :			
Date of Accident :	Time of Accident	<input type="radio"/> AM	<input type="radio"/> PM
Date accident reported :			
Were you paid in full for the day of the accident?			<input type="radio"/> Yes <input type="radio"/> No
Supervisor's Name	Was supervisor notified?	<input type="radio"/> Yes	<input type="radio"/> No

Name of Witness(es):

Information About the Nature and Cause of Accident

Machine, tool or object causing injury			
Was safety equipment used?	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No	Where	
Was time lost from work?	<input type="radio"/> Yes <input type="radio"/> No	If yes, how long?	
Date returned to work			
Could this accident have been avoided?	<input type="radio"/> Yes <input type="radio"/> No	If yes, how?	

Employee Signature	Date
Supervisor Signature	Date

WORKERS' COMPENSATION

Panel Physicians Form



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@yorkrsg.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

757-220-8300

PHONE

2) Dr. A. Stankiewicz/Velocity

NAME

4347 Newtown Ave. Ste. 100

ADDRESS

Williamsburg, VA 23188

757 772-6124

PHONE

3) Dr. E. Obie/MD Express

NAME

120 Monticello Ave.

ADDRESS

Williamsburg, VA 23185

757-564-3627

PHONE

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



WILLIAM & MARY
ENVIRONMENT, HEALTH
& SAFETY OFFICE

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: _____