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

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
Accident Investigation Form

INJURED EMPLOYEE NAME: ___________________________  JOB TITLE: ___________________________
(If an injury occurred)

DEPARTMENT: ___________________________  INCIDENT DATE/TIME: ___________________________

SUPERVISOR: ___________________________  INVESTIGATION DATE: ___________________________

SUMMARY OF WHAT HAPPENED:

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

ATTACH SKETCH AND PHOTOGRAPHS AS NECESSARY.

SITE OBSERVATIONS:

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

ATTACH 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 REQUEST HAVE BEEN INITIATED IF NEEDED.

FOLLOW UP ACTIONS TAKEN/REQUIRED (For completed actions list the date completed. For future actions list the estimated date of completion.)

LESIONS LEARNED:

INVESTIGATED BY: ____________________________

DATE: __________________