# Employer's First Report of Accident

This report must be received by the Workers' Compensation Office, HR/PR MS 3C3, within three (3) days of the date of injury

## Part I- To be completed by Employee. (Please answer all questions completely.)

Employee:

| | |
|---|---|
| 1. Name: Last First Middle | 2. G Number:<br><br>3. Preferred Language: |
| 4. Home Address:<br>Street: Apt #:<br><br>City: State: Zip: | 5. Phone Numbers:<br>Home:<br><br>Work:<br><br>Cell: |
| 6a. Marital Status: Single [ ] Married [ ] Divorced [ ] Widowed [ ]<br><br>6b. Sex: Male [ ] Female [ ] | 7. Date of Birth: |
| 8a. Occupation at the time of accident (state position title):<br><br>8b. Department | 8c. Immediate Supervisor: |
| 9. I authorize release of claim information to (department personnel): | |
| 10a. Start Date in current position:<br><br>10b.Time started working on day of injury: | 10c. Hours worked per day:<br><br>10d. Days worked per week: |

Time and Place of Accident:

| | |
|---|---|
| 11a. Date of Accident:<br><br>11b. Time of Accident: | 11c: Date of incapacitation (began WC leave):<br><br>11d: Hour of incapacitation (began WC leave): |
| 12. Date Accident Reported: | 13. Supervisor or authority to whom reported: |
| 14. Fully describe the area and conditions where the incident occurred (include campus and location): | |
| 15. Who else was involved or was a witness? | |

Nature and Cause of Accident:

| 16a. Machine, tool, or object causing injury or illness (specify part of machine, etc.)<br><br>16b. What safeguards were provided?<br><br>16c. Were safeguards utilized by employee? Yes [ ] No [ ]<br><br>16d. If not, explain: |
|---|
| 17. Describe in detail how the accident happened: |
| 18. Describe nature of injury or illness, including specific parts of body affected: |
| 19. Was on site minor first aid administered? Yes [ ] No [ ] |
| 20. Were University Police notified? Yes [ ] No [ ] If so UPD report # |
| 21. Does the employee need to seek medical treatment? Yes [ ] No [ ]<br><br>Note: Treatment must be with an approved panel physician. The panel of physicians is located on the GMU Human Resources and Payroll website (http://hr.gmu.edu/workerscomp/wc.php) or by calling the Benefits team at 703.993.2600. ***Cases requiring immediate medical attention may proceed to closest emergency facility***. |
| 22a. Are temporary modified duties required? Yes [ ] No [ ]<br><br>22b. Will additional medical treatment by a physician be necessary? Yes [ ] No [ ] |
| 23a. Has employee returned to work? Yes [ ] No [ ] 23 d. Has employee lost time as a result of incident Yes [ ] No [ ]<br><br>23b. If yes, date of return:<br><br>23c. If no, probable length of disability (doctor's estimate): |

Comments:

*Falsification of State records is a Group III offense, which may result in discharge. I certify the above information is true and complete.*

Employee's Signature: ________________________________________________________ Date: __________________________

Prepared by: __________________________________________________Date: ___________________ Phone No. _______________

## Supplemental Information

| Employee's Name: |
|---|
| Date of Injury/Illness: |

Part II- To be completed by Employee's Supervisor. (Please answer all questions completely.)

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|---|
| 1a. Date when you first knew of the accident:<br><br>1b. By whom were you first notified: |
| 2a. Do you concur with the employee's statements in Part I? Yes [ ] No [ ]<br><br>2b. If no, what discrepancies do you observe? |
| 3a. Was the injury/illness job related?: Yes [ ] No [ ]<br>3b. Did incident occur during employees normal job duties?: Yes [ ] No [ ]<br>3c. Did incident occur on agency owned/maintained property?: Yes [ ] No [ ] |
| 4a. Was the employee on duty?: Yes [ ] No [ ]<br>4b. If not, was employee on employer premises as a condition of employment?: Yes [ ] No [ ]<br>4c. If not, was employee on employer premises as a member of the general public?: Yes [ ] No [ ]<br>4d. If the injury/illness occurred off employer premises, was employee present as a condition of employment or in travel status and engaged in work or travel function?: Yes [ ] No [ ] |
| 5a. Was a safety appliance or regulation established at time of accident/illness?: Yes [ ] No [ ] N/A [ ]<br>5b. Was employee aware of the safety appliance or regulation at time of accident/illness?: Yes [ ] No [ ] N/A [ ]<br>5c. Was the safety appliance or regulation in use at time of accident/illness?: Yes [ ] No [ ] N/A [ ]<br>5d. Was the accident caused by employee's failure to use safety appliance or observe regulations?: Yes [ ] No [ ] N/A [ ]<br>Explain: |
| 6. How could the injury/illness have been prevented? |
| 7. What precautions have been taken to prevent future accidents of this nature? |
| 8. Supervisor(s) who should be notified of employees schedule and/or job modifications (list name and contact information) |

Comments:

Supervisor's Signature and Title: ___________________________________________________________________________

Date: _________________________

Human Resources & Payroll
4400 University Drive, MS 3C3, Fairfax, Virginia 22030
Phone: 703-993-2600; Fax: 703-993-2601

# Panel of Physicians- Initial Visit (Virginia)

**SUBJECT: Panel Physician Selection**

**If you are an employee injured in a work related accident and require immediate care, you should report to the nearest medical facility for treatment. All other work-related injuries or illnesses requiring a medical evaluation and all additional treatment or referrals must be reported to your supervisor and the Workers' Compensation office as soon as possible.**

**Please note that every employee, even if you are not seeking medical treatment, must complete and return this form to the Workers' Compensation office.**

**Please indicate your choice of physician from the panel listed on page 2, sign the form on page 3 and return it as soon as possible.**

**If you have questions regarding any part of the Workers' Compensation process, please contact a Benefits and Workers' Compensation Specialist, 703.993.2600 or benefits@gmu.edu.**

**The completed form needs to be sent to:**

**The Workers' Compensation Office**
**Human Resources & Payroll**
**MSN 3C3**
**Fax: 703.993.2601**
**Email: benefits@gmu.edu**

**Please Note: If you participate with Kaiser Permanente health please seek medical attention with Kaiser at (703)359-7878.**

| Providers for Initial Visits | | |
|---|---|---|
| Kaiser- if you have Kaiser go to your primary care physician | | |
| Dr. Lawrence Stein<br>Virginia Hospital Center | 1701 N George Mason Drive<br>Arlington, VA 22205 | 703.558.5000 |
| Dr. Alan W. Richey<br>Inova Primary Care Center- Ballston | 1005 North Glebe Road Suite 160<br>Arlington, VA 22201 | 571.492.3080 |
| Dr. Amit Chandra<br>Inova Emergency Care Center | 6355 Walker Lane<br>Alexandria, VA 22310 | 703.797.6800 |
| Dr. George W. Jastrzebski<br>Inova Emergency Care Center- Fairfax | 4315 Chain Bridge Road<br>Fairfax, VA 22030 | 703.771.2857 |
| Dr. Catherine Pipan<br>Inova Medical Center-Dulles South | 24801 Pinebrook Road<br>Chantilly, VA 20152 | 703.722.2500 |
| Dr. Roma Akosua Edoo-Sowah<br>Inova Urgent Care of Vienna | 100 Maple Ave. East<br>Vienna, VA 22180 | 703.938.5300 |
| Dr. Jasmin Kilayko Cole<br>Inova Urgent Care of Centreville | 6201 Centreville Road Suite 200<br>Centreville, VA 20121 | 703.830.5600 |
| Dr. Kurt Rodney<br>Inova Urgent Care of Purcellville | 205 East Hirst Road Suite 101<br>Purcellville, VA 20132 | 540.338.4995 |
| Dr. George W. Jastrzebski<br>Inova Emergency Care Center-Reston | 11901 Baron Cameron Avenue<br>Reston, VA 20190 | 703.668.8333 |
| Dr. William E. Hauda<br>Inova Emergency Care Center- Leesburg | 224 Cornwall Street<br>Leesburg, VA 20176 | 703.737.7520 |
| Dr. Da Hye Hwang<br>Inova Emergency Care Center- Lorton | 9321 Sanger Street<br>Lorton, VA 22079 | 703.982.8324 |
| Dr. Carlos Martinez<br>Inova- Urgent Care Center- Woodbridge | 14605 Potomac Branch Drive<br>Suite 210 Woodbridge, VA 22191 | 571.492.3070 |
| Dr. Minh K. Tran<br>Patient First- Fairfax | 10100 Fairfax Blvd.<br>Fairfax, VA 22030 | 703.679.1876 |
| Dr. Mark Paster<br>Patient First- Alexandria | 6311 Richmond Highway<br>Alexandria, VA 22306 | 703.647.6087 |
| Dr. Akila Iyer<br>Patient First-Leesburg | 601 Potomac Station Drive<br>Leesburg, VA 20176 | 703.840.1396 |
| Dr. Akila Iyer<br>Patient First-Chantilly | 3918 Centreville Road<br>Chantilly, VA 20151 | 703.657.6925 |
| Dr. John Bigbee<br>Patient First- Manassas | 9715 Liberia Ave<br>Manassas, VA 20110 | 571.229.1797 |
| Dr. Kelvin Kemp<br>Patient First-Garrisonville | 60 Prosperity Lane<br>Stafford, VA 22556 | 540.658.2811 |
| Dr. Kevin Donaghey<br>Patient First- Fredericksburg | 3031 Plank Road<br>Fredericksburg, VA 22401 | 540.736.5043 |
| Dr. Robert Latimer, Jr.<br>Bull Run Family Practice | 8640 Sudley Road Suite 203<br>Manassas, VA 20110 | 703.368.3161 |
| Dr. Sean Duffy<br>Concentra Medical Center | 45305 Catalina Court, Suite 103<br>Sterling, VA 20166 | 703.435.7656 |
| Dr. Mark Davis<br>Virginia Medical Acute Care | 5501 Backlick Road Ste 105<br>Springfield, VA 22151 | 703-564-5998 |
| | | |

**The Doctor I have selected is_________________________________________________.**

_________ I **am seeking** medical treatment**.**

_________ I **am not seeking** medical treatment at this time. However, I understand that if medical treatment becomes necessary I must use the physician I have selected above.

**NOTE: You may not choose a chiropractor or a physical therapist as a primary source for treatment. All visits to chiropractors and/or physical therapists must have a referral from a licensed physician.**

**ACKNOWLEDGMENT**

I have reviewed the panel of physicians provided. I will notify the physician's office that this may be a work related injury/illness and that the carrier is the Commonwealth of Virginia, Managed Care Innovations. The billing address for claims is P.O. Box 1140 Richmond, VA 23218. Physicians may obtain claim confirmation through Workers' Compensation Office, 703.993.2600 or benefits@gmu.edu

Initial Here: ________

**RELEASE OF INFORMATION:**

In order to safeguard your privacy, the Workers' Compensation Office requests your signed consent to furnish information regarding your medical status and sick and/or personal leave balances to your supervisor, GMU departments of Human Resources & Payroll, and/or the ADA committee "on a need to know basis". Workers' Compensation Office asks that you consent to the acquisitions or release of such information in writing. So far as possible, this information will be kept confidential.

Initial Here: ________

Print Name: ________________________________________________

Signature: _______________________________________________ Date: _________________

If you need further information regarding this procedure, please contact the Virginia Workers' Compensation Commission at (804) 367-8600.