

Nature and Cause of Accident:

16a. Machine, tool, or object causing injury or illness (specify part of machine, etc.)
16b. What safeguards were provided?
16c. Were safeguards utilized by employee? Yes [] No []
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 [] 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 []
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 []
23b. If yes, date of return:
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.)

1a. Date when you first knew of the accident:
1b. By whom were you first notified:
2a. Do you concur with the employee's statements in Part I? Yes [] No []
2b. If no, what discrepancies do you observe?
3a. Was the injury/illness job related?: Yes [] No []
3b. Did incident occur during employees normal job duties?: Yes [] No []
3c. Did incident occur on agency owned/maintained property?: Yes [] No []
4a. Was the employee on duty?: Yes [] No []
4b. If not, was employee on employer premises as a condition of employment?: Yes [] No []
4c. If not, was employee on employer premises as a member of the general public?: Yes [] No []
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 []
5b. Was employee aware of the safety appliance or regulation at time of accident/illness?: Yes [] No [] N/A []
5c. Was the safety appliance or regulation in use at time of accident/illness?: Yes [] No [] N/A []
5d. Was the accident caused by employee's failure to use safety appliance or observe regulations?: Yes [] No [] N/A []
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.

NOTE: You do not have to see doctor listed if s/he is not available. See first available in practice

Providers for Initial Visits		
Kaiser- if you have Kaiser go to your primary care physician		
Dr. Peter A Vasquez, MD Virginia Hospital Center	1625 N George Mason Dr. St.475 Arlington, VA 22205	703.717.4245
Dr. Alan W. Richey Inova Primary Care Center- Ballston	1005 North Glebe Road Suite 160 Arlington, VA 22201	571.492.3080
Dr. Amit Chandra Inova Emergency Care Center	6355 Walker Lane Alexandria, VA 22310	703.797.6800
Dr. George W. Jastrzebski Inova Emergency Care Center- Fairfax	4315 Chain Bridge Road Fairfax, VA 22030	703.771.2857
Dr. Catherine Pipan Inova Medical Center-Dulles South	24801 Pinebrook Road Chantilly, VA 20152	703.722.2500
Dr. Roma Akosua Edoe-Sowah Inova Urgent Care of Vienna	100 Maple Ave. East Vienna, VA 22180	703.938.5300
Dr. Jasmin Kilayko Cole Inova Urgent Care of Centreville	6201 Centreville Road Suite 200 Centreville, VA 20121	703.830.5600
Dr. Kurt Rodney Inova Urgent Care of Purcellville	205 East Hirst Road Suite 101 Purcellville, VA 20132	540.338.4995
Dr. George W. Jastrzebski Inova Emergency Care Center-Reston	11901 Baron Cameron Avenue Reston, VA 20190	703.668.8333
Dr. William E. Hauda Inova Emergency Care Center- Leesburg	224 Cornwall Street Leesburg, VA 20176	703.737.7520
Dr. Da Hye Hwang Inova Emergency Care Center- Lorton	9321 Sanger Street Lorton, VA 22079	703.982.8324
Dr. Carlos Martinez Inova- Urgent Care Center- Woodbridge	14605 Potomac Branch Drive Suite 210 Woodbridge, VA 22191	571.492.3070
Dr. Minh K. Tran Patient First- Fairfax	10100 Fairfax Blvd. Fairfax, VA 22030	703.679.1876
Dr. Mark Paster Patient First- Alexandria	6311 Richmond Highway Alexandria, VA 22306	703.647.6087
Dr. Khurram Ali Patient First-Leesburg	601 Potomac Station Drive Leesburg, VA 20176	703.840.1396
Dr. Minh Tran Patient First-Chantilly	3918 Centreville Road Chantilly, VA 20151	703.657.6925
Dr. Starina Jose Patient First- Manassas	9715 Liberia Ave Manassas, VA 20110	571.229.1797
Dr. Kelvin Kemp Patient First-Garrisonville	60 Prosperity Lane Stafford, VA 22556	540.658.2811
Dr. Michael Kim Patient First- Fredericksburg	3031 Plank Road Fredericksburg, VA 22401	540.736.5043
Dr. Raven Davis Patient First- Falls Church	502 West Broad Street # 2 Falls Church, VA 22046	571.421.8431
Dr. Robert Latimer, Jr. Bull Run Family Practice	8640 Sudley Road Suite 203 Manassas, VA 20110	703.368.3161
Dr. Mark Davis Virginia Medical Acute Care	5501 Backlick Road Ste 105 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.