



Employee's Report of Injury

(Please Print – Please complete and return to Supervisor)

EMPLOYEE INFORMATION

| | | | | | |
|-----------------------|-------------|-------------------------|---------|--|----------------|
| Employee's Last Name: | | First: | Middle: | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth: |
| | | | | | / / |
| Street Address: | | Social Security Number: | | Home Telephone No: | |
| | | | | () | |
| PO Box: | City: | State: | | ZIP Code: | |
| | | | | | |
| Department: | Supervisor: | | | Job Title: | |
| | | | | | |

ACCIDENT INFORMATION

| | | |
|--|--|-----------------------|
| Date of Accident: | Time of Accident: | Location of Accident: |
| / / | <input type="checkbox"/> am <input type="checkbox"/> pm | |
| Witnesses: | | |
| | | |
| Were you performing a part of the normal job duty: | Report Prepared by (if different than the injured employee): | |
| <input type="checkbox"/> yes <input type="checkbox"/> no | | |

What were you doing when the accident occurred? Describe the activity as well as the tools, equipment, or material that you was using. Examples: "climbing a ladder while carrying materials".

What happened? Describe how the injury occurred. Examples: "when ladder slipped on wet floor, I fell 20 feet".

What was the injury or illness? Describe the part of the body that was affected and how it was affected. Example: "strained lower back".

What object or substance directly harmed you? Example: "concrete floor".

What can be done to prevent a reoccurrence?

EMERGENCY MEDICAL TREATMENT YES NO (IF YES, PLEASE INDICATED WHERE)

| | | | |
|-------------|--|---|---|
| Treated by: | <input type="checkbox"/> Madison Family Physicians | <input type="checkbox"/> Orange Family Physicians | |
| Hospital: | <input type="checkbox"/> Culpeper Memorial | <input type="checkbox"/> Martha Jefferson | <input type="checkbox"/> University of Virginia |

In accordance with Virginia State Law, I hereby authorize Virginia Association of Counties Group Self-Insurance Associations (VACoGSIA), the insurer, or their representatives to be furnished with any information or facts, including records, diagnosis, medical treatment and prognosis, estimates of disability, and recommendations for further treatment. This information is to be used for the sole purpose of evaluating and handling any claim, and assuring timely medical care as a result of the incident occurring on or about the above noted date for no other purpose, now or in the future. I also agree that photographic carbonless copy of this release shall be as valid as the original.

Employee's Signature

Date