Employer's Accident Report

(formerly: Employer's First Report of Accident)
Virginia Workers' Compensation Commission
1000 DMV Drive Richmond, VA 23220
See instructions on the reverse of this form

The boxes to the right are for the use of the insurer	Reason for filing	VWC file number
	Insurer code or PEO Ref. No. S0225	Insurer location 762
	Insurer claim number	

Employer

1. Name of employer (trading as or doing business as, if applicable)	2. Federal Tax Identification Number	3. Employer's Case No. (if applicable)
Virginia Tech	54-6001805	
4. Mailing address Southgate Center (0318) Blacksburg, VA 24061	5. Location (if different from mailing address)	
6. Parent corporation /Policy Named Insured (if applicable) or PEO name Commonwealth of Virginia	7. Nature of business State Government	
8. Name and Address of Insurer or self-insurer for this claim Managed Care Innovations	9. Policy number Self-Insured	10. Effective date 06/15/98

Time and Place of Accident

11. City or county where accident occurred	12. Date of injury	13. Hour of injury a.m. p.m. 13a. Time began work a.m. p. m.	14. Date of incapacity	15. Hour of incapacity

16. Was employee paid in full of day of injury? ☐ Yes ☐ No	17. Was employee paid in full for day incapacity began? ☐ Yes ☐ No

18. Date injury or illness reported	19. Person to whom reported	20. Name of other witness	21. If fatal, give date of death

Employee

22. Name of employee (Last, First, Middle)	23. Phone Number	24. Sex ☐ Male ☐ Female
25. Address	26. Date of Birth 28. Employee ID Number	27. Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed
29. Occupation at time of injury or illness	30. Is worker covered by PEO policy? ☐ Yes ☐ No	31. Number of dependent children

32. How long in current job?	33. How long with current employer?	34. Was employee paid on a piece work or hourly basis? ☐ Piece work ☐ Hourly
35. Hours worked per day	36. Days worked per week	37. Value of perquisites per week Food/Meals $ Lodging $ Tips $ Other $
38. Wages per hour $	39. Earnings per week (inc. overtime) $	

Nature and Cause of Accident

40. Machine, tool, or object causing injury or illness	41. Specify part of machine, etc.
42. Describe fully how injury or illness occurred	
43. Describe nature of injury or illness, including parts of body affected	43a. Overnight inpatient hospitalization? ☐ Yes ☐ No 43b. Treated in Emergency Room? ☐ Yes ☐ No
44. Physician (name and address)	45. Hospital (name and address)

46. Probable length of disability	47. Has employee returned to work? ☐ Yes ☐ No	If Yes	48. At what wage?	49. On what date?

50. EMPLOYER: prepared by (name, signature, title)	51. Date	52. Phone Number
53. INSURER: (name of processor)	54. Date	55. Phone number
56. THIRD PARTY ADMINISTRATOR (if applicable)	57. Address	58. Phone number

This report is required by the Virginia Workers' Compensation Act