

**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*

<b>The boxes to the right are for the use of the insurer</b>	Reason for filing	VWC file number
	Insurer code or PEO Ref. No.	Insurer location
	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)
4. Mailing address	5. Location (if different from mailing address)	
6. Parent corporation /Policy Named Insured (if applicable) or PEO name	7. Nature of business	
8. Name and Address of Insurer or self-insurer for this claim	9. Policy number	10. Effective date

Time and Place of Accident				
11. City or county where accident occurred	12. Date of injury	13. Hour of injury <input type="text"/> a.m. <input type="text"/> p.m. 13a. Time began work <input type="text"/> a.m. <input type="text"/> p.m.	14. Date of incapacity	15. Hour of incapacity
16. Was employee paid in full for day of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. Was employee paid in full for day incapacity began? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	
25. Address		26. Date of birth	27. Marital status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
29. Occupation at time of injury or illness		28. Social security number	31. Number of dependent children <input type="text"/>	
32. How long in current job?	33. Date of Hire	30. Is worker covered by PEO policy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
35. Hours worked per day <input type="text"/>	36. Days worked per week <input type="text"/>	34. Was employee paid on a piece work or hourly basis? <input type="checkbox"/> Piece work <input type="checkbox"/> Hourly		
38. Wages per hour \$ <input type="text"/>	39. Earnings per week (inc. overtime) \$ <input type="text"/>	37. Value of perquisites per week Food/meals    Lodging    Tips    Other \$                    \$                    \$                    \$		

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? <input type="checkbox"/> Yes <input type="checkbox"/> No 43b. Treated in Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No	
44. Physician (name and address)		45. Hospital or Clinic (name and address)		
46. Probable length of disability	47. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> 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



# ATTENDING PHYSICIAN'S STATEMENT

Please Complete and Mail To:

VFIS  
P.O. Box 5126, York, Pennsylvania 17405-9726  
Call (717) 741-0911 · Toll Free: (800) 233-1957  
Fax # (717) 747-7051

PLEASE COMPLETE THIS FORM  
IN FULL FOR PROMPT SERVICE.

NOTE: IMPORTANT STATE INFORMATION  
ON REVERSE SIDE

Name of Patient \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Regular Occupation \_\_\_\_\_  
Name of Insured Organization \_\_\_\_\_ Policy No. \_\_\_\_\_

### IMPORTANT

#### Have Insured Member (Patient) sign following Authorization

I hereby authorize any hospital, physician, or other person who has attended me or examined me to furnish to VFIS, Inc., any and all information with respect to any accident or illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature \_\_\_\_\_  
Insured Member Patient

### PART B - TO BE COMPLETED BY ATTENDING PHYSICIAN

Dear Doctor:

The above named individual has filed a claim for benefits as a result of the Accident/Sickness for which he is currently or has been under your care. In order that we might give his claim proper attention, would you kindly answer the following questions at your earliest convenience and forward completed form to us. *\*The Company does not assume any expense incidental to the completion of this form.*

(1) Diagnosis and Concurrent Conditions -  
(If Fracture or Dislocation, Describe Nature and Location,  
If Sickness Describe Nature)

(2A) When Did Symptoms First Appear or Accident Happen? Date \_\_\_\_\_ Year \_\_\_\_\_

(B) When Did Patient Consult You For This Condition? Date \_\_\_\_\_ Year \_\_\_\_\_

(C) Has Patient Ever Had Same or Similar Condition?  
(If Yes, State When and Describe) Yes \_\_\_\_\_ No \_\_\_\_\_ Year \_\_\_\_\_

(3A) Nature of Surgical Procedure, If Any (Describe Fully) - Date Performed \_\_\_\_\_ Year \_\_\_\_\_

(B) If Performed in Hospital, Give Name and Address - Inpatient \_\_\_\_\_ Outpatient \_\_\_\_\_

(4) What other Services, If Any, Did You Provide Patient?

(5) Is Patient Still Under Your Care For This Condition?  
If "No" Give Date Your Services Terminated. Yes \_\_\_\_\_ No \_\_\_\_\_  
Date \_\_\_\_\_

(6A) How Long Was or Will Patient Be Continuously  
Totally Disabled (Unable To perform Regular Occupation)  
Due to Diagnosis in #1 Above? From \_\_\_\_\_ Year Thru \_\_\_\_\_ Year

(B) How Long Was or Will Patient Be Partially Disabled? From \_\_\_\_\_ Year Thru \_\_\_\_\_ Year

(C) Approximate Date Patient Will Return To Work If  
Still Disabled. \_\_\_\_\_ Year \_\_\_\_\_ Year

Date \_\_\_\_\_ Signature \_\_\_\_\_

Street Address \_\_\_\_\_ City or Town \_\_\_\_\_ (attending physician) \_\_\_\_\_ (degree) \_\_\_\_\_ (telephone no.) \_\_\_\_\_  
State or Providence \_\_\_\_\_ Zip Code \_\_\_\_\_

# ACCIDENT/SICKNESS CLAIM REPORT

Please Complete and Mail To:

VFIS

P.O. Box 5126, York, Pennsylvania 17405-9726  
Call (717) 741-0911 • Toll Free: (800) 233-1957  
Fax (717) 747-7051

**PLEASE COMPLETE THIS FORM  
IN FULL FOR PROMPT SERVICE.**

NOTE: IMPORTANT STATE INFORMATION  
ON REVERSE SIDE



## TO BE COMPLETED BY INJURED PERSON

DATE OF THIS REPORT \_\_\_\_\_

Name \_\_\_\_\_ Home Telephone No. (AC) \_\_\_\_\_ )  
 Work Telephone No. (AC) \_\_\_\_\_ )  
 Soc. Sec. No. \_\_\_\_\_ )

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Accident or Organization's Activity \_\_\_\_\_ Year: \_\_\_\_\_ Occurred \_\_\_\_\_ am  
 Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Marital Status \_\_\_\_\_ pm

Full-Time/Regular Occupation \_\_\_\_\_ Income: Weekly \_\_\_\_\_ Yearly \_\_\_\_\_

Name and address of full-time employer \_\_\_\_\_

Employer Telephone No.: \_\_\_\_\_ Length of employment in this work: \_\_\_\_\_

Please completely answer the next three questions:

1. What activity were you involved in when injured or became ill?

2. How did accident or sickness occur?

3. What is your injury or sickness?

Give date of first day of full-time occupation missed due to above accident and sickness \_\_\_\_\_

Give date you were able to return to work \_\_\_\_\_

Attending Physician's Name, Address and Telephone Number \_\_\_\_\_

Name and Address of Hospital \_\_\_\_\_

Dates Hospitalized	
From _____	Year _____
To _____	Year _____

## AUTHORIZATION TO DOCTOR, HOSPITAL, CLINIC, OR WORKERS' COMPENSATION CARRIER TO RELEASE MEDICAL INFORMATION

Please furnish VFIS, Inc. with information they may request regarding details of my past medical history and physical condition. A photostatic copy of this authorization shall be considered as valid as the original. Your help is greatly appreciated.

Signature of Injured Member or Next of Kin \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_

## TO BE COMPLETED BY OFFICIAL OF NAMED INSURED ORGANIZATION (must be other than Injured Person)

- Was the injured person a member of your organization at the time of the above described incident? Yes No
- If claimant is a member of organization, please circle type of member: junior adult auxiliary (Circle one)
- Was the injured person engaged in an authorized activity of your organization at the time of injury or commencement of sickness? Yes No
- Name and Address of Insured Organization \_\_\_\_\_
- Policy Number \_\_\_\_\_
- Organization Telephone Number \_\_\_\_\_
- Home Telephone Number of Official Signing Below \_\_\_\_\_

I certify that the above is true.

• Signed \_\_\_\_\_ • Title \_\_\_\_\_ • Date \_\_\_\_\_

Item No. A:01:001 (01/03)