## First Report of Injury

Virginia Workers' Compensation Commission 1000 DMV Drive Richmond Virginia 23220 1-877-664-2566

SEE INSTRUCTIONS ON REVERSE SIDE



Reason for filing: VWC Jurisdiction Claim #: (If assigned)

SEE INSTRUCTIONS ON REVERSE SIDE		www.vwc.state.va.us		Claim Administrator File#:	
Employer					
Employer's Legal Name		Federal Employer Identification Number (FEIN)			
Employer's Mailing Address					
Name/FEIN of Entity on Policy			Nature of Business		
Name and Address of Insurer or Self-Insurer for this Claim			Policy Number		
Time and Place of Accide					
Location where accident occurred	Date of injury			Hour of injury	. 🗌 p.m.
Date injury or illness reported	If fatal, give date of death If fatal, give number of dependent children		dren		ivorced
Injured Worker					
Name of Injured Worker Phone Number			Injured Worker ID Number		
Injured Worker's mailing address				Type of ID Social Security No. Green Card Unknown	<ul><li>Employment Visa</li><li>Passport No.</li></ul>
Occupation at time of injury or illness Date of birth		h		Sex	
Nature and Cause of Accident				Male	Female
Machine, tool, or object causing injury or illness					
Describe fully how injury or illness occurred					
Describe nature of injury, occupational disease, or illness, including body parts affected					
Submitter (name signature title)				Dhono number	
		Date		Phone number	
Submitter's Address					

# First Report of Injury

## **Filing Instructions**

The Virginia Workers' Compensation Act requires that **ALL** injuries occurring in the course of employment be reported to the Commission pursuant to Va. Code §65.2-900.

### Employer

The employer is responsible for accurately completing all sections of this form when an employee is injured. It should be typed or legibly printed, signed, and dated by the preparer. Send the original form to the claim administrator for the insurance company who provided insurance coverage on the date of the occurrence. The claim administrator will report this information to the Commission. Contact your workers' compensation insurance provider for additional information.

#### **Claim Administrator**

Claim administrators who are EDI enabled will use the information contained on the paper form and submit electronic data to the Commission.

Claim administrators who are NOT EDI enabled must immediately file the completed form with the Commission. Please note: EDI is mandatory no later than June 30, 2009, after which time paper reports will no longer be accepted. Until you are in EDI production, mail the completed form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220. At the top of the form, use a numerical code (1-7) to indicate the reason for filing the form for accidents meeting one of the filing criterion.\* If none of the criteria apply, you must still report the accident, but may use either Form 45A or this form to do so. (Leave "reason for filing" blank in such a case.)

For questions or assistance in completing the form, please contact the Commission toll-free at 877-664-2566.

\*Criteria for filing are: (1) lost time exceeds seven days; (2) medical expenses exceed \$1,000.00; (3) compensability is denied; (4) issues are disputed; (5) accident resulted in death; (6) permanent disability or disfigurement may be involved; and (7) a specific request is made by the Virginia Workers' Compensation Commission.