## 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 REVE	KSE SIDE	WWW.VWC.S	tate.va.us	Claim Administrator File#:	
Employer					
Employer's Legal Name			Federal Emp	oloyer Identification Number (FEIN)	
Employer's Mailing Address			1		
Name/FEIN of Entity on Policy		Nature of Business			
Name and Address of Insurer or Self-In		Policy Numb	ber		
Time and Place of Accide			•		
Location where accident occurred Date of injury				Hour of injury	
				□ a.m. □ p.m.	
Date injury or illness reported If fatal, give date of death			If fatal, give marital status		
If fatal, give		ve number of dependent children		Single Divorced   Married Widowed	
Injured Worker	I			1	
Name of Injured Worker Phone Number				Injured Worker ID Number	
Injured Worker's mailing address				Type of ID	
				Social Security No. Employment Visa	
				Green Card Passport No.	
Occupation at time of injury or illness Date of b		birth		Sex	
				Male Female	
Nature and Cause of Accident					
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					
Signatures					
Submitter (name, signature, title)		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.