

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	VWC file number	Reason for filing
	Insurer code	Insurer location
	Insurer claim number	

Employer			
1. Name of employer		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 (if applicable)		7. Nature of business	
8. Insurer (name and location)		9. Policy number	10. Effective date
Time and Place of Accident			
11. City or county where accident occurred		Did accident occur on <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Date of injury		15. Hour of injury	13. State property? <input type="checkbox"/> Yes <input type="checkbox"/> No
16. Date of incapacity		17. Hour of incapacity	
18. Was employee paid in full for day of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		19. Was employee paid in full for day incapacity began? <input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Date injury or illness reported	21. Person to whom reported	22. Name of other witness	23. If fatal, give date of death
Employee			
24. Name of employee (Last, First, Middle)		25. Phone number	26. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
27. Address		28. Date of birth	29. Marital status <input type="checkbox"/> Single <input type="checkbox"/> Divorced
		30. Social security number	<input type="checkbox"/> Married <input type="checkbox"/> Widowed
31. Occupation at time of injury or illness		32. Department	33. Number of dependent children
34. How long in current job?	35. How long with current employer?	36. Was employee paid on a piece work or hourly basis? <input type="checkbox"/> Piece work <input type="checkbox"/> Hourly	
37. Hours worked per day	38. Days worked per week	39. Value of perquisites per week	
40. Wages per hour \$	41. Earnings per week (inc. overtime) \$	Food/meals \$	Lodging \$
		Tips \$	Other \$
Nature and Cause of Accident			
42. Machine, tool, or object causing injury or illness		43. Specify part of machine, etc.	44. Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No
46. Describe fully how injury or illness occurred		Were safeguards or safety equipment	45. Utilized? <input type="checkbox"/> Yes <input type="checkbox"/> No
47. Describe nature of injury or illness, including parts of body affected			
48. Physician (name and address)		49. Hospital (name and address)	
50. Probable length of disability	51. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes 52. At what wage? \$	53. On what date?
54. EMPLOYER: prepared by (name, signature, title)		55. Date	56. Phone number
57. INSURER: processed by		58. Date	59. Phone number