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	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)	7. Nature of business	
8. Name of Insurer and Address	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 a.m. p.m.	14. Date of incapacity	15. Hour of incapacity
16. Was employee paid in full for 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	27. Marital status ☐ Single ☐ Divorced ☐ Married ☐ Widowed
	28. Social security number	
29. Occupation at time of injury or illness	30. Department	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		
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