

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
		13. State property? <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Date of injury	15. Hour of injury	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 of 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 Food/meals Lodging Tips Other \$ \$ \$ \$
40. Wages per hour \$	41. Earnings per week (inc. overtime) \$	

Nature and Cause of Accident		
42. Machine, tool, or object causing injury or illness	43. Specify part of machine, etc.	Were safeguards or safety equipment <input type="checkbox"/> Yes <input type="checkbox"/> No
46. Describe fully how injury or illness occurred		
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

This report is required by Virginia Workers' Compensation Act

First Report of Accident
 VWC Form No. 3 (rev. 10/1/91)

INSTRUCTIONS

Employer's First Report of Accident VWC Form No. 3

Employer

1. Fill out this form whenever one of your employees is injured. Provide all the information requested, except the information in the top right corner. **Please type or print all information in black ink.** Your signature is required at the bottom of the form.
2. Send the original beige form to your insurance carrier or claims servicing agency for processing. If you are self-insured, send it to your organization's designated office for handling workers' compensation claims.
3. If you are an employer subject to OSHA record-keeping requirements, you may retain a copy of this completed form as a supplementary record of occupational injury or illness. Use block #3 (Employer's Case No.) to cross-reference your master log of accidents and illnesses.
4. If you need additional copies of this form, please request them from your insurance carrier or claims servicing agency.

Insurance carriers, self-insured employers, and authorized representatives

1. For accidents meeting one of the seven criteria for establishing Commission Case File,* submit the original beige form and one copy to the Virginia Workers' Compensation Commission at 1000 DMV Drive, Richmond VA 23220. The code for the reason for filing should be written at the top right of the form.
2. When processing these forms prior to transmittal to the Commission, please include the information requested at the top right of the form, verify that the carrier name and policy number given by the employer are accurate, and enter your name and phone number, and the date of processing at the bottom of the form.
3. Insurer code at the top right of the form refers to the five-digit code assigned by NCCI. If you are self-insured, it refers to a similar five-digit number assigned by the Virginia Workers' Compensation Commission.
4. Additional copies of this form are available without cost by writing to the Commission. Please note that color coding of the forms greatly increases the Commission's efficiency in processing claims, and that any alternate versions of the form you develop yourself require prior approval by the Commission. Write to "Forms" at the listed Virginia Workers' Compensation Commission address.

*The criteria are: (1) lost time exceeds seven days, (2) medical expenses exceed \$1,000, (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's Workers' Compensation Commission.