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
	DN0002	DN0005
	Insurer code or PEO Ref. No.	Insurer location
	DN0006	NA
	Insurer claim number	
	DN0015	

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)
DN0018	DN0016	DN0026
4. Mailing address	5. Location (if different from mailing address)	
DNs 0165, 0166, 0167, 0168, 0169, 0170	NA	
6. Parent corporation /Policy Named Insured (if applicable) or PEO name	7. Nature of business (NAICS code, if applicable)	
DN0314	DN0025 (NAICS)	
8. Name and Address of Insurer or self-insurer for this claim	9. Policy number	10. Effective date
DNs 0007, 0010, 0011, 0012, 0013, 0014, 0136, 0200	DN0028	NA

Time and Place of Accident

11. City or county where accident occurred	12. Date of injury	13. Hour of injury DN0032	14. Date of incapacity	15. Hour of incapacity
DNs 0033, 0119	DN0031	☐ a.m. ☐ p.m 13a. Time began work NA ☐ a.m. ☐ p.m	NA	NA

16. Was employee paid in full for day of injury	17. Was employee paid in full for day incapacity began?
☐ Yes ☐ No NA	☐ Yes ☐ No NA

18. Date injury or illness reported	19. Person to whom reported	20. Name of other witness	21. If fatal, give date of death
DN0040	NA	NA	DN0057

Employee

22. Name of employee (Last, First, Middle)	23. Phone number	24. Sex DN0053
DNs 0043, 0044, 0045	DN0051	☐ Male ☐ Female
25. Address	26. Date of birth	27. Marital status
DNs 0046, 0047, 0048, 0049, 0050	DN0052	☐ Single ☐ Divorced
	28. Social security number DNs	DN0054
	0270, 0042, 0152, 0153, 0154, 0156	☐ Married ☐ Widowed

29. Occupation at time of injury or illness (SOC code, if applicable)	30. Is worker covered by PEO policy?	31. Number of dependent children
DN0059 (SOC - Manual Classification Code)	☐ Yes ☐ No NA	☐ DN0055

32. How long in current job?	33.Date of Hire	34. Was employee paid on a piece work or hourly basis?
NA	NA	NA ☐ Piece work ☐ Hourly

35. Hours worked	36. Days worked	37. Value of perquisites per week			
per day ☐ NA	per week ☐ NA	Food/meals	Lodging	Tips	Other
38. Wages per hour	39. Earnings per week (inc. overtime)				
$ NA	$ NA	$ NA	$ NA	$ NA	$ NA

Nature and Cause of Accident

40. Machine, tool, or object causing injury or illness	41. Specify part of machine, etc.
DN0037 (WCIO)	NA

42. Describe fully how injury or illness occurred
DN0038

43. Describe nature of injury or illness, including parts of body affected	43a. Overnight inpatient hospitalization?
DNs 0035, 0036	☐ Yes NA ☐ No 43b. Treated in Emergency Room? ☐ Yes ☐ No

44. Physician (name and address)	45. Hospital or Clinic (name and address)
NA	NA

46. Probable length of disability	47. Has employee returned to work?	If yes	48. At what wage?	49. On what date?
NA	NA ☐ Yes ☐ No		NA	NA

50. EMPLOYER: prepared by (name, signature, title)	51. Date	52. Phone number
NA	NA	NA
53. INSURER: (name of processor)	54. Date	55. Phone number
NA	NA	NA

56. THIRD PARTY ADMINISTRATOR (if applicable)	57. Address	58. Phone number
DNs 0187, 0188	DNs 0010, 0011, 0012, 0013, 0014, 0136 , 0200	NA (Get from TP Agreement)

FILING INSTRUCTIONS

(Instructions Updated 09/01/07)

Employer's Accident Report
VWC Form No. 3

This form must be completed by the employer, the employer's representative or the insurer and filed within 10 days after the notice of a work-related injury, occupational illness/disease or if the occurrence resulted in death to the worker. If the employer or its representative completed the form, the form should be submitted to the insurer who provided insurance coverage on the date of the occurrence, and the insurer will immediately file the original and one copy of the completed form with the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220. The additional copy of the Employer's Accident Report (VWC Form No. 3) will be furnished to the Virginia Department of Labor and Industry. The filing of this form with the Commission is a requirement under §65.2-900 of the Act.

Employer

1. As the employer, you are responsible for accurately completing all sections of this form when one of your employees is injured. It should be typed or legibly printed, signed, and dated by the preparer. Your insurance carrier, claims servicing agency, self-insured employer's representative or third-party administrator should complete the information in the top right corner.
2. The "trading as" or "doing business" as name should appear in Block l and the Parent Corporation (policy named insured) should be reflected in Block 6.
3. Provide the insurance information (name, address, policy number, and effective date of the policy), that covers the date that the work-related accident or occupational illness or disease occurred, in Blocks 8, 9 and 10.
4. As the employer, if you are subject to OSHA record-keeping requirements, a copy of this completed form may be retained as a supplementary record of an occupational illness or disease. Use Block 3 (Employer's Case No.) to cross-reference any master-log of work-related accidents, illnesses, diseases and death claims.
5. Send the original beige form to your insurance carrier, claims servicing agency, or third-party administrator for processing.

Insurance Companies, Self-Insurers, Servicing Companies, Authorized Representatives, Third-Party Administrators (TPA's), Group Self-Insurance Associations, and Professional Employer Organizations (PEO's):

1. The insurer should provide the information at the top right of the form. Use a numerical code (1-7) to indicate the reason for filing the form for accidents meeting one of the filing criteria's*. When using a code reason (7) provide the VWC file number. Note that the insurer code refers to the five-digit numeric code assigned by the National Counsel on Compensation Insurance (NCCI). The Virginia Workers' Compensation Commission assigns self-insured employers a similar five-digit code number. Professional Employer Organizations (PEO's) must use the VWC reference number.
2. If the work-related accident or occupational illness or disease does not meet one of the filing criteria*, a Report of Minor Injuries (VWC Form 45-A) should be completed for the occurrence and timely filed with the Virginia Workers' Compensation Commission.
3. Verify the insurance information that was provided by the employer (name, address, policy number, and effective date of the policy) as it appears on this form and ensure that it covers the date that the accident or occupational illness or disease occurred (Blocks 8, 9 and 10).
4. Provide the applicable information requested in Blocks 50 through 58 as it applies.

Forms: Additional copies of this form are available without cost by writing to the Commission. Address your inquiries to "Forms" at the listed Virginia Workers' Compensation Commission address. This form is also available on the Commission's website, at www.vwc.state.va.us. ***Note:*** color-coding of the forms greatly increases the Commission's efficiency in processing claims, and that any alternative versions of the form you develop yourself require prior approval by the Commission. The original copy of the Employer's Accident Report (VWC Form No. 3) should be on beige paper.

Electronic Filing: The Employer's Accident Report (VWC Form No. 3) can be filed electronically through the Commission's Website, at www.vwc.state.va.us. For questions or assistance regarding the electronic filing process, please contact our "Information Systems Department" at (804) 367-2084 or in writing. Also, provide a brief description of your current data processing and communication capabilities.

For questions or assistance with completing the form, please contact the First Report's Unit at (804) 367-0072 or the Commission's Toll-free number at (1-877) 664-2566.

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*The criteria's for filing 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 Workers' Compensation Commission.

Report of Minor Injuries

Submit to: Virginia Workers' Compensation Commission
1000 DMV Drive Richmond VA 23220

45 - A

See instructions on the reverse of this form.

Insurer

Name of insurer or self-insurer DN0188	Period covered From NA / NA / NA To NA / NA / NA .
Address DNs 0010, 0011, 0012, 0013, 0014, 0136, + 0200	Insurer code: DN0006 Insurer location: NA Date filed: DN0003 Contact Person: NA Phone number: NA

Payments

NOTE: If this accident has been previously reported on Form 45A, pl ace an "X" in the box by the entry.

☐	Name of employee DNs 0043, 0044, 0045	Social Security Number DNs 0270,0042,0152,0153,0154,0156	Date of accident DN0031
	Address of employee DNs 0046, 0047, 0048, 0049, 0050, 0155	Name and address of employer DNs 0018, 0165, 0166, 0167, 0168, 0169, 0170	
		Employer Tax Identification Number DN0016	Monthly medical cost NA
☐	Name of employee	Social Security Number	Date of accident
	Address of employee	Name and address of employer	
		Employer Tax Identification Number	Monthly medical cost
☐	Name of employee	Social Security Number	Date of accident
	Address of employee	Name and address of employer	
		Employer Tax Identification Number	Monthly medical cost
☐	Name of employee	Social Security Number	Date of accident
	Address of employee	Name and address of employer	
		Employer Tax Identification Number	Monthly medical cost
☐	Name of employee	Social Security Number	Date of accident
	Address of employee	Name and address of employer	
		Employer Tax Identification Number	Monthly medical cost
☐	Name of employee	Social Security Number	Date of accident
	Address of employee	Name and address of employer	
		Employer Tax Identification Number	Monthly medical cost
☐	Name of employee	Social Security Number	Date of accident
	Address of employee	Name and address of employer	
		Employer Tax Identification Number	Monthly medical cost

FILING INSTRUCTIONS
(Instructions Updated 09/01/07)

Report of Minor Injuries
VWC Form No. 45A

1. This form is used to report minor injuries which do not: a) result in lost time of more than seven days; b) involve more than $1,000 in medical costs; or c) involve a fatality, permanent disability, or disfigurement.* The information you provide is used both to report on medical costs and provides proper notification to injured employees of their rights under the Virginia Workers' Compensation Act.

2. The insurer should provide the information at the top of the form and the Report of Minor Injuries (VWC Form No. 45A) should be submitted to the Commission on a monthly basis.

3. Type or legibly print all information on the form for each employee including, the social security number, accident date and the federal tax identification number for all employers.

4. Place a check in the box to the left of the employee's name whenever the accident has been previously reported to the Commission as a Minor Injury Claim and additional medical costs were incurred, but the total medical costs have not exceeded $1,000.

5. If this is the initial reporting of a claim, and there has been no medical cost, place a zero ($0) in the box for monthly medical costs. It is not necessary to report zero ($0) medical costs each month after the initial reporting of the injury.

6. **Forms**: Additional copies of this form are available without cost by writing to the Commission. Address your inquiry to "Forms" at the listed Virginia Workers' Compensation Commission address. Please note that any alternate versions of the form you develop yourself require prior approval by the Commission.

7. **Electronic Filing**: The Report of Minor Injuries (VWC Form No. 45A) can be filed electronically through the Commission's website, www.vwc.state.va.us and selecting "Electronic Filing Services". If you are interested in the batch processing method, please contact our "Information Systems Department" at (804) 367-2084 or in writing. Please provide a brief description of your current data processing and communication capabilities.

8. For questions or assistance with completing this form, please contact the First Reports Unit at (804) 367-0072 or the Commission's toll free number (1-877) 664-2566.

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*More specifically, the seven situations in which you should NOT use this form, and should instead file an Employer's Accident Report are when (1) lost time exceeds seven days, (2) medical expenses exceed $1,000, (3) compensability is denied, (4) issues are disputed, (5) the 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.

Report of Medical Costs

Submit to: Virginia Workers' Compensation Commission
1000 DMV Drive Richmond VA 23220

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See instructions on the reverse of this form.

Insurer

Name of insurer or self-insurer DN 0188	Period covered From NA / NA / NA To NA / NA / NA		
Address DNs 0010, 0011, 0012, 0013, 0014, 0136, + 0200	Insurer code DN0006	Insurer location NA	Date filed DN0003
	Contact Person NA		Phone number NA

Payments

NOTE: This report is to be filed every six months and SHOULD NOT include costs previously reported.

1. VWC File Number DN0005			
2. Name of employee DNs 0043, 0044, 0455		3. Social Security Number 0270, 0042, 0152, 0153, 0154, 0156	4. Date of accident DN0031
5. Hospital costs DN0216 (value = 360)	6. Physician costs DN0216 (value = 350)	7. Miscellaneous costs DN0216 (value = 370)	8. Rehabilitative costs DN0216 (value = 460)
1. VWC File Number			
2. Name of employee		3. Social Security Number	4. Date of accident
5. Hospital costs	6. Physician costs	7. Miscellaneous costs	8. Rehabilitative costs
1. VWC File Number			
2. Name of employee		3. Social Security Number	4. Date of accident
5. Hospital costs	6. Physician costs	7. Miscellaneous costs	8. Rehabilitative costs
1. VWC File Number			
2. Name of employee		3. Social Security Number	4. Date of accident
5. Hospital costs	6. Physician costs	7. Miscellaneous costs	8. Rehabilitative costs
1. VWC File Number			
2. Name of employee		3. Social Security Number	4. Date of accident
5. Hospital costs	6. Physician costs	7. Miscellaneous costs	8. Rehabilitative costs
1. VWC File Number			
2. Name of employee		3. Social Security Number	4. Date of accident
5. Hospital costs	6. Physician costs	7. Miscellaneous costs	8. Rehabilitative costs
1. VWC File Number			
2. Name of employee		3. Social Security Number	4. Date of accident
5. Hospital costs	6. Physician costs	7. Miscellaneous costs	8. Rehabilitative costs

FILING INSTRUCTIONS

(Instructions Updated 09/01/07)

Report of Medical Costs
VWC Form No. 45G

1. This form is to be used to report medical costs on accidents that were previously reported to the Virginia Workers' Compensation Commission on an **Employer's Accident Report (VWC Form No. 3)** because they (a) result in lost time of more than seven days; (b) involve more than $1,000 in medical costs; or (c) involve any fatality, permanent disability, or disfigurement. This report is to be submitted every six months.*

2. The insurer or its designated representative should complete all of the information requested at the top of the form.

3. Type or legibly print all information on the form for each employee, including the VWC File Number, Social Security Number, and Date of Accident, along with a breakdown of the medical expenses incurred. *Note*: If you do not have a VWC File Number, please ensure that you have filed an Employer's Accident Report (VWC Form No. 3) with the Commission

4. Incomplete or illegible forms will be returned to the sender for proper completion.

5. If no medical costs were incurred on a particular claim during the reporting period, these claims should not be submitted to the Commission reflecting a zero ($0) amount.

6. **Forms**: Additional copies of this form are available without cost by writing to the Commission. This form is also available on the Commission's Website, at www.vwc.state.va.us. Address your inquiries to "Forms" at the listed Virginia Workers' Compensation Commission address. Please note that any alternative versions of the form you develop require prior approval of the Commission.

7. **Electronic Filing**: The Report of Medical Costs (VWC Form No. 45G) can be filed electronically through the Commission's Website at www.vwc.state.va.us and selecting Electronic Filing Services. If you are interested in the batch processing method, please contact our "Information Systems Department" at (804) 367-2084 or in writing. Please provide a brief description of you current data processing and communication capabilities.

8. For questions or assistance with completing this form, please contact the Awards Unit using the Commission's Toll Free number at (1-877) 664-2566.

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*If this accident has **not** been previously reported to the Commission, and does **not** meet one of the following seven criteria, you should use VWC Form No. 45A (Report of Minor Injuries) rather than this report: (1) lost time exceeds seven days, (2) medical expenses exceed $1,000, (3) compensability is denied, (4) issues are disputed, (5) the 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.