

# How to Report Workers' Compensation Injuries

## Incident Reporting Procedures Employee Work-Related Injuries

*In life-threatening situations, immediately seek medical assistance, then complete these claim forms!*

To ensure the safety and well-being of our employees, we request your help in reporting work-related injuries and illnesses as soon as possible. This allows prompt medical attention as well as the correction of any existing hazardous conditions.

### How Are Injuries Reported?

- Injured worker notifies supervisor.
- Together, the Supervisor **and** Injured worker immediately call the Company Nurse Injury Hotline: 1-888-770-0925.
- Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment with an approved panel of physicians. *(Failure to go to an approved physician on the panel may result in your bill being denied.)*

Workers' Compensation claims are administered and adjusted by a third party administrator. Employees should report all work-related injuries/illnesses to their supervisor within **24 hours of injury**.

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### Supervisors Responsibilities Checklist

**Make sure the following forms are completed:**

- Supervisor's Investigation Report** – Obtain a detailed description of the accident, as well as a specific place and time at which the injury occurred. Provide pictures of area where injury occurred if applicable.
- Fax the **Supervisor's Investigation Report and Doctor's Note** to the HR Office @ 540-422-8318 or email to [riskmanagement@fauquiercounty.gov](mailto:riskmanagement@fauquiercounty.gov).
- If the employee seeks medical treatment, HR **must** receive a Return to Work Note **prior** to their planned date of return. Preferably 48 hours prior to return if released with restrictions to allow for review.

*Failure to report such activities may affect benefits from workers' compensation.*

If you have any questions, please feel free to contact the HR Office at (540) 422-8300.

# IN CASE OF WORKPLACE INJURY:

ACCION a seguir en caso de un accidente en el trabajo



# 1-888-770-0925

▶ **AVAILABLE 24 HOURS A DAY**

- 1** ▶ **Injured worker notifies supervisor.**  
*Empleado lesionado notifica a su supervisor.*
- 2** ▶ **Supervisor and Injured worker immediately call injury hotline.**  
*Supervisor y Empleado lesionado llaman inmediatamente a la línea de enfermeros/as.*
- 3** ▶ **Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment.**  
*Profesional Médico obtiene información por teléfono y asiste al empleado lesionado en localizar el tratamiento médico adecuado.*

EMPLOYER NAME  
(NOMBRE DE COMPANIA)

SEARCH CODE  
(CÓDIGO DEL BÚSQUEDA)

Fauquier County, VA

V030

### Notice to Employer/Supervisor:

Please post copies of this poster in multiple locations within your worksite. If the injury is non-life threatening, please call Company Nurse prior to seeking treatment. Minor injuries should be reported prior to leaving the job site when possible.

Visit us online: [www.CompanyNurse.com](http://www.CompanyNurse.com)

## SUPERVISOR'S INVESTIGATION REPORT

Employee's Name	Department	Job Title	How Long on Job
Date of Injury/Illness	Time	Location	Body part injured

What happened?

Root Cause Analysis - Check ALL that apply to this accident			
Unsafe Act(s)		Unsafe Condition(s)	
Improper work technique		Poor Workstation design	
Safety rule violation		Unsafe Operation Method	
Improper PPE or PPE not used		Improper Maintenance	
Operating without authority		Lack of direct supervision	
Failure to warn or secure		Insufficient Training	
Operating at improper speeds		Lack of experience	
By-passing safety devices		Insufficient knowledge of job	
Protective equipment not in use		Slippery conditions	
Improper loading or placement		Excessive noise	
Improper lifting		Inadequate guarding of hazards	
Servicing machinery in motion		Defective tools/equipment	
Horseplay		Poor housekeeping	
Drug or alcohol use		Insufficient lighting	

What are the contributing factors to the root cause of the accident?

What should be done to prevent a future similar injury/illness?

Who will initiate the above corrective action?

Do you agree with the employee's statements on the Official Occupational Injury/Illness Report? Yes/No (circle one)

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

**PHYSICAL CAPABILITIES FORM**

Name: \_\_\_\_\_ Injury Date: \_\_\_\_\_ Age: \_\_\_\_\_

Employer \_\_\_\_\_ Department/School \_\_\_\_\_

Injury/Complaint(s) \_\_\_\_\_

Diagnosis \_\_\_\_\_

Is complaint(s)/Diagnosis work related? Yes  No

In an eight hour day, the patient can (please circle full capacity for each activity and check appropriate box)

		With Restrictions	Continuously	Comments _____
Stand	1 2 3 4 5 6 7 8 Hrs.	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____
Walk	1 2 3 4 5 6 7 8 Hrs.	<input type="checkbox"/>	<input type="checkbox"/>	
Sit	1 2 3 4 5 6 7 8 Hrs.	<input type="checkbox"/>	<input type="checkbox"/>	

In an eight-hour day, the patient can:

Lift up to	Never	Occasionally 0-33%	Frequently 34%-66%	Continuously 67%-100%
10 Lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carry up to:				
10 Lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient can use hands for repetitive actions such as:

Simple Grasping                      Pushing/Pulling                      Fine Manipulation  
 Yes  No                       Yes  No                       Yes  No

Patient can use feet for repetitive movements as in operating foot controls

Right foot Yes  No                       Left foot Yes  No                       Both Yes  No

Patient is restricted by environmental factors (heat/cold, dust, dampness, heights, fumes, gas, etc.)

No restrictions                       Limited restrictions (please specify below)

If position requires, Patient can fully and safely operate vehicle without accompaniment Yes  No

Patient can return to work on this date: \_\_\_/\_\_\_/\_\_\_ and can assume: Full duty  Modified duty

If modified duty, patient can return to full duty on (estimate date): \_\_\_/\_\_\_/\_\_\_

Modified duty restrictions: \_\_\_\_\_

Medication prescribed: \_\_\_\_\_

Does medication prevent patient from working on or around equipment, machinery, or driving? Yes  No

If answer is "yes", explain: \_\_\_\_\_

Date of follow up appointment \_\_\_/\_\_\_/\_\_\_ If referred, physician's name \_\_\_\_\_

Will patient require any assertive devices or braces to return to work Yes (specify below)  No

Describe assertive devices needed, and restrictions they may cause: \_\_\_\_\_

Other comments: \_\_\_\_\_

Physician's name (please print): \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_



# Workers' Compensation Temporary Prescription ID Card

## VACORP

### »» To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

### Atencion Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 800.945.5951.

### »» To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

### Pharmacy Processing Steps

- Step 1: Enter bin number 003858
- Step 2: Enter processor control A4
- Step 3: Enter the group number as it appears above
- Step 4: Enter the injured worker's nine-digit ID number
- Step 5: Enter the injured worker's first and last name
- Step 6: Enter the injured worker's date of injury  
(enter in DOI field in the format YYYYMMDD)

#### Express Scripts

ID #: \_\_\_\_\_

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM/DD/YYYY

Group #: **M5L2017**

Employee Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Thank you** for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

*Please see other side for a list of participating retail network pharmacies.*

### »» To the Supervisor: Please fill in the information requested for the injured worker.

#### Employee Information

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
First M Last

\_\_\_\_\_  
Street Address or PO Box

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
City State ZIP

#### Employer Name

\_\_\_\_\_

## Participating Retail Network Pharmacies

ACCREDITED HEALTH GROUP

BECKLEY ARH PHARMACY

BLOOM PHARMACY

BOARDWATER DRUG BY  
WAGS

CAREPOINT PARTNERS

CONTINUUMCARE  
PHARMACY

COSTCO

CRITICAL CARE SYSTEMS

CVS

DULLES URGENT CARE  
CENTER

EMERGENCY PHYS  
IMMEDIATE CARE

ER PHYSICIANS IMMEDIATE  
CARE

EXTENDED CARE ASSOCIATES

FARM FRESH PHARMACY

FOOD LION PHARMACY

GIANT DISCOUNT DRUG

GIANT EAGLE

GIANT PHARMACY

HARRIS TETTER PHARMACY

HOME CARE PHARMACY

JEFFERSON URGENT CARE

KAISER PERMANENTE PHCY

KMART PHARMACY

KROGER PHARMACY

MARTINS PHARMACY

MARTIN'S PHARMACY

NEIGHBORCARE PHARMACY

PATIENT FIRST

PHARMERICA

PROGRESS PHARMACY  
SERVICES

RICHMOND SOUTHSIDE  
TRTMNT CNTR

RICHMOND TREATMENT  
CENTER

RITE AID

RX SERVICE

SAFEWAY PHARMACY

SAMS

SAM'S CLUB

SHOPPERS PHARMACY

SHOPPERS PHARMACY #978

STERLING AUTOMATED  
REFILL CNTR

TARGET PHARMACY

UKROP'S PHARMACY

WALGREEN'S

WAL-MART

WEGMANS FOOD MARKETS

WEGMANS PHARMACY

WEIS PHARMACY

WILLIAMSONS PHARMACY



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