

# 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.

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.
- Fax the **Supervisor Investigation Report** to the HR Office **immediately**, 540-422-8318.
- 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.

Again, thank you for your efforts!

# 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"/>	<div style="border: 1px solid black; padding: 5px;">                     _____                      _____                      _____                 </div>
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: \_\_\_/\_\_\_/\_\_\_

Please send all bills to The Human Resources Department, 320 Hospital Drive, Suite 34, Warrenton, VA. 20186 Attention: Risk Management