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 or PEO Ref. No. **S0225**	Insurer location **762**
	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)
RADFORD UNIVERSITY	**546 00 1789**	
4. Mailing address **Radford University Dept of Human Resources 314B Tyler Place, P.O. Box 6889 Radford, Virginia 24142**	5. Location (if different from mailing address) **N/A**	
6. Parent corporation /Policy Named Insured (if applicable) or PEO name **Commonwealth of Virginia**	7. Nature of business **State Government**	
8. Name and Address of Insurer or self-insurer for this claim **Managed Care Innovations P.O. Box 1140, Richmond, VA 23208-1121**	9. Policy number **Self-Insured**	10. Effective date **July 1, 1992**

Time and Place of Accident

11. City or county where accident occurred	12. Date of injury	13. Hour of injury a.m. ☐ p.m. ☐ 13a. Time began work a.m. ☐ p.m. ☐	14. Date of incapacity	15. Hour of incapacity

16. Was employee paid in full of 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 28. Social Security Number	27. Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed
29. Occupation at time of injury or illness	30. Is worker covered by PEO policy? ☐ Yes ☐ No	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) $	$ **N/A**	$ **N/A**	$ **N/A**	$ **N/A**

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 arts of body affected	43a. Overnight inpatient hospitalization? ☐ Yes ☐ No 43b. Treated in Emergency Room? ☐ Yes ☐ No

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

NOTE: Detail guidelines for completing the EAR are found at Item #4, Forms and Instructions.

INSTRUCTIONS

Employer's Accident Report
VWC Form No. 3

Employer

1. Fill out this form whenever one of your employees is injured or reports a possible work related injury or illness. Provide **all** the information requested, except the information in the top right corner. **Please type if possible. If you print the form please do so legibly in black ink. Do not complete the form in cursive.** 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 a Case File,* submit the original beige form and one copy to Managed Care Innovations (MCI), P.O. Box 1140, Richmond, Virginia 23208-1121. 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 MCI, 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 MCI. Please note that color coding of the forms greatly increases MCI's efficiency in processing claims, and that any alternate versions of the form you develop yourself require prior approval by MCI. Write to "Forms" at the listed MCI.

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*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 MCI.