First Report of Injury

Virginia Workers' Compensation Commission 1000 DMV Drive Richmond Virginia 23220 1-877-664-2566



Reason for filing:	
VWC Jurisdiction Claim #:	
(If assigned)	
	_

SEE INSTRUCTIONS ON REVERSE SIDE

www.vwc.state.va.us

(If assigned)	
Claim Administrator File#:	

	Employer								
Employer'	's Legal Name				Federal Employer Identification Number (FEIN)				
Employer's	s Mailing Address								
,	- ···-································								
Name/FEIN of Entity on Policy				Nature of Bu	usiness				
Name and Address of Insurer or Self-Insurer for this Claim			Policy Numb	er					
	Time and Place of Accid	lont							
Location w	where accident occurred	Date of ir	niurv			Hour of injury			
			J. J			, , ,		_	
							a.m.	☐ p.m.	
Date injury	y or illness reported	If fatal o	ive date of de	-ath		If fatal, give mari	tal status		
Date injuit	y or	rata., g					ta. otatao		
						Single	Divo	orced	
		If fatal, g	ive number o	of dependent child	dren	☐ Married	☐ Wid	owed	
						Warried			
	Injured Worker								
Name of I	Injured Worker njured Worker		Phone Num	nber		Injured Worker II			
Name of I			Phone Num	nber					
			Phone Num	nber					
	njured Worker		Phone Num	nber		Injured Worker II	D Number		
	njured Worker		Phone Num	nber		Injured Worker II	D Number	☐ Employment Visa	_
	njured Worker		Phone Num	nber		Injured Worker II	D Number		
	njured Worker		Phone Num	nber		Injured Worker II Type of ID Social Securi Green Card	D Number	☐ Employment Visa	
Injured Wo	njured Worker orker's mailing address					Injured Worker II Type of ID Social Securi Green Card Unknown	D Number	☐ Employment Visa	
Injured Wo	njured Worker		Phone Num Date of birt			Injured Worker II Type of ID Social Securi Green Card	D Number	☐ Employment Visa	_
Injured Wo	njured Worker orker's mailing address n at time of injury or illness					Injured Worker II Type of ID Social Securi Green Card Unknown	D Number	☐ Employment Visa	_
Injured Wo	njured Worker orker's mailing address n at time of injury or illness Nature and Cause of Ac					Injured Worker II Type of ID Social Securi Green Card Unknown Sex	D Number	☐ Employment Visa ☐ Passport No.	
Injured Wo	njured Worker orker's mailing address n at time of injury or illness					Injured Worker II Type of ID Social Securi Green Card Unknown Sex	D Number	☐ Employment Visa ☐ Passport No.	_
Occupation Machine, t	njured Worker orker's mailing address n at time of injury or illness Nature and Cause of Action, or object causing injury	or illness				Injured Worker II Type of ID Social Securi Green Card Unknown Sex	D Number	☐ Employment Visa ☐ Passport No.	
Occupation Machine, t	njured Worker orker's mailing address n at time of injury or illness Nature and Cause of Ac	or illness				Injured Worker II Type of ID Social Securi Green Card Unknown Sex	D Number	☐ Employment Visa ☐ Passport No.	
Occupation Machine, t	njured Worker orker's mailing address n at time of injury or illness Nature and Cause of Action, or object causing injury	or illness				Injured Worker II Type of ID Social Securi Green Card Unknown Sex	D Number	☐ Employment Visa ☐ Passport No.	
Occupation Machine, t	njured Worker orker's mailing address n at time of injury or illness Nature and Cause of Action, or object causing injury ully how injury or illness occ	or illness	Date of birt	th	affected	Injured Worker II Type of ID Social Securi Green Card Unknown Sex	D Number	☐ Employment Visa ☐ Passport No.	_
Occupation Machine, t	njured Worker orker's mailing address n at time of injury or illness Nature and Cause of Action, or object causing injury	or illness	Date of birt	th	affected	Injured Worker II Type of ID Social Securi Green Card Unknown Sex	D Number	☐ Employment Visa ☐ Passport No.	
Occupation Machine, t	njured Worker orker's mailing address n at time of injury or illness Nature and Cause of Action, or object causing injury ully how injury or illness occupationa	or illness	Date of birt	th	affected	Injured Worker II Type of ID Social Securi Green Card Unknown Sex	D Number	☐ Employment Visa ☐ Passport No.	
Occupation Machine, t Describe for	njured Worker orker's mailing address n at time of injury or illness Nature and Cause of Action, or object causing injury ully how injury or illness occurature of injury, occupational	or illness	Date of birt	th ding body parts a	affected	Injured Worker II Type of ID Social Securi Green Card Unknown Sex Male	D Number	☐ Employment Visa ☐ Passport No.	
Occupation Machine, t Describe for	njured Worker orker's mailing address n at time of injury or illness Nature and Cause of Action, or object causing injury ully how injury or illness occupationa	or illness	Date of birt	th	affected	Injured Worker II Type of ID Social Securi Green Card Unknown Sex	D Number	☐ Employment Visa ☐ Passport No.	
Occupation Machine, t Describe for the submitter of the	njured Worker orker's mailing address n at time of injury or illness Nature and Cause of Actool, or object causing injury ully how injury or illness occupational signatures (name, signature, title)	or illness	Date of birt	th ding body parts a	affected	Injured Worker II Type of ID Social Securi Green Card Unknown Sex Male	D Number	☐ Employment Visa ☐ Passport No.	
Occupation Machine, t Describe for	njured Worker orker's mailing address n at time of injury or illness Nature and Cause of Actool, or object causing injury ully how injury or illness occupational signatures (name, signature, title)	or illness	Date of birt	th ding body parts a	affected	Injured Worker II Type of ID Social Securi Green Card Unknown Sex Male	D Number	☐ Employment Visa ☐ Passport No.	
Occupation Machine, t Describe for the submitter of the	njured Worker orker's mailing address n at time of injury or illness Nature and Cause of Actool, or object causing injury ully how injury or illness occupational signatures (name, signature, title)	or illness	Date of birt	th ding body parts a	affected	Injured Worker II Type of ID Social Securi Green Card Unknown Sex Male	D Number	☐ Employment Visa ☐ Passport No.	

First Report of Injury

Filing Instructions

The Virginia Workers' Compensation Act requires that **ALL** injuries occurring in the course of employment be reported to the Commission pursuant to Va. Code §65.2-900.

Employer

The employer is responsible for accurately completing all sections of this form when an employee is injured. It should be typed or legibly printed, signed, and dated by the preparer. Send the original form to the claim administrator for the insurance company who provided insurance coverage on the date of the occurrence. The claim administrator will report this information to the Commission. Contact your workers' compensation insurance provider for additional information.

Claim Administrator

Claim administrators who are EDI enabled will use the information contained on the paper form and submit electronic data to the Commission.

Claim administrators who are NOT EDI enabled must immediately file the completed form with the Commission. Please note: EDI is mandatory no later than June 30, 2009, after which time paper reports will no longer be accepted. Until you are in EDI production, mail the completed form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220. At the top of the form, use a numerical code (1-7) to indicate the reason for filing the form for accidents meeting one of the filing criterion.* If none of the criteria apply, you must still report the accident, but may use either Form 45A or this form to do so. (Leave "reason for filing" blank in such a case.)

For questions or assistance in completing the form, please contact the Commission toll-free at 877-664-2566.

^{*}Criteria for filing are: (1) lost time exceeds seven days; (2) medical expenses exceed \$1,000.00; (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.