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.	Insurer location
	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)
4. Mailing address	5. Location (if different from mailing address)	
6. Parent corporation /Policy Named Insured (if applicable) or PEO name	7. Nature of business	
8. Name and Address of Insurer or self-insurer for this claim	9. Policy number	10. Effective date

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 for 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.Date of Hire	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) $		

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 parts of body affected	43a. Overnight inpatient hospitalization? ☐ Yes ☐ No 43b. Treated in Emergency Room? ☐ Yes ☐ No
44. Physician (name and address)	45. Hospital or Clinic (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

INSTRUCTIONS

Employer's Accident Report
(formerly Employer's First Report of Accident)
VWC Form No. 3

Employer

1. Fill out this form whenever one of your employees is injured. Provide all the information requested, except the information in the top right corner. **Please type or print all information in black ink.** Your signature is required on line 50 of the form.

2. Send the original beige form to your insurance carrier, claims servicing agency, or third party administrator 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, claims servicing agency, or third party administrator.

Insurance carriers, self-insured employers, Professional Employer Organizations (PEO's), and authorized representatives

1. For accidents meeting one of the seven criteria for establishing a Commission Case File,* submit the original beige form and one copy to the Virginia Workers' Compensation Commission at 1000 DMV Drive, Richmond VA 23220. 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 the Commission, 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. A PEO must use the VWCC reference number.

4. Additional copies of this form are available without cost by writing to the Commission. Please note that 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. Write to "Forms" at the listed Virginia Workers' Compensation Commission address.

5. On Lines 8 and 9, the employer or carrier is to give the name of the responsible carrier as set forth on the policy (line 8) and that carrier's policy number (line 9).

*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 the Virginia Workers' Compensation Commission.