County of Henrico, Department of Finance, Risk Management Division

WORKERS' COMPENSATION EMPLOYEE'S REPORT OF INJURY

Use a separate sheet if necessary. Refer to Workers' Compensation Reporting Flowchart for additional information.

EMPLOYEE INFORMATION

Full Name: _____

Division/School: _____ Occupation: _____

Date of Birth: _____ Gender: _____ Email: _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Home Address: _____

ACCIDENT INFORMATION

Date Reported: _____ To Whom: _____ Was CARE24 Called? ☐ YES ☐ NO

Date of Injury: _____ Time of Injury: _____ ☐ AM ☐ PM

Location of Injury: _____

Police Report Number (if applicable): _____

Describe in detail how the injury or illness occurred. If applicable, describe the machine, tool, or object causing injury or illness.

BODY PART AFFECTED (Check the box next to each body part injured.)

Head

- ☐ Face/Head
- ☐ Nose
- ☐ Mouth
- ☐ Teeth
- ☐ Left Eye
- ☐ Right Eye
- ☐ Left Ear
- ☐ Right Ear

Trunk

- ☐ Neck/Throat
- ☐ Chest
- ☐ Upper Back
- ☐ Abdomen
- ☐ Mid Back
- ☐ Groin/Pelvis
- ☐ Lower Back
- ☐ Buttocks/Tailbone

Upper Extremities

- ☐ Left Shoulder
- ☐ Right Shoulder
- ☐ Left Upper Arm
- ☐ Right Upper Arm
- ☐ Left Elbow
- ☐ Right Elbow
- ☐ Left Lower Arm
- ☐ Right Lower Arm
- ☐ Left Wrist
- ☐ Right Wrist
- ☐ Left Hand
- ☐ Right Hand
- ☐ Left Finger(s)/Thumb
- ☐ Right Finger(s)/Thumb

Lower Extremities

- ☐ Left Hip
- ☐ Right Hip
- ☐ Left Upper Leg
- ☐ Right Upper Leg
- ☐ Left Knee
- ☐ Right Knee
- ☐ Left Lower Leg
- ☐ Right Lower Leg
- ☐ Left Ankle
- ☐ Right Ankle
- ☐ Left Foot
- ☐ Right Foot
- ☐ Left Toe(s)
- ☐ Right Toe(s)

☐ **Other:** _____

NATURE OF INJURY

☐ Amputation ☐ Bite/Sting ☐ Body Fluid Exposure ☐ Bruise/Contusion
☐ Burn ☐ Concussion ☐ Cut/Laceration/Puncture ☐ Electric Shock
☐ Dislocation ☐ Fall/Slip ☐ Fracture/Broken Bone ☐ Heat Stroke
☐ Sprain/Strain Other: _____

MEDICAL CARE INFORMATION

Were you treated for your injury? ☐ YES ☐ NO Did you require EMS transport? ☐ YES ☐ NO

If treated, please list all physicians/medical facilities that provided initial and/or follow-up treatment.

Physician/Medical Facility: _____

Physician/Medical Facility: _____

Physician/Medical Facility: _____

Did you aggravate a previous injury/condition? ☐ YES (if yes, explain below) ☐ NO

Have you had any previous workers' compensation claims? ☐ YES (if yes, list date and type of injury below) ☐ NO

Did you miss time from work? ☐ YES ☐ NO If yes, Date(s) missed: _____

Have you returned to work? ☐ YES ☐ NO If yes, Date returned: _____ ☐ FULL DUTY ☐ LIGHT DUTY

ADDITIONAL INFORMATION

Other Person(s) Involved (provide name and phone number):

Witnesses (provide name and phone number):

SUPERVISOR INFORMATION

Name:	Email:
Work Phone:	Work Cell:

SIGNATURES

INJURED EMPLOYEE: I have reviewed the above information is true to the best of my knowledge.

Employee's Signature: Date:

SUPERVISOR: I have reviewed for completeness and not concurrence

Supervisor's Signature: Date:

PLEASE SUBMIT COMPLETED FORM AND RELATED DOCUMENTS TO RISK MANAGEMENT WITHIN 24 HRS OR NEXT BUSINESS DAY.

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PO Box 5231, Janesville, WI 53547-5231

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