County of Henrico

Department of Finance, Risk Management Division

EMPLOYEE'S REPORT OF INJURY

Immediately report injury/incident, regardless of the extent of the personal injury, to your supervisor. Please call Care 24 at **уррπфрпπлусс** *anŘ ǊŜŦŜǊ ǘƻ the instructions listed on the HR Employee Portal under "My Workplace" for reporting workplace injuries. Please complete this form along with the other necessary forms outlined in the "Worker's Compensation Reporting Flowchart" and send to PMA within 48 hours (or next business day if occurrence is on weekend or holiday). Use a separate sheet of paper if necessary.*

EMPLOYEE INFORMATION

Department: ______________________ **Division / School:** ______________________

Name of Employee: ______________________ **Gender:** ☐ Male ☐ Female

Last *First* *Middle*

Home Address: ______________________

Street *City* *State* *Zip*

Home or Cell Phone: ____________ **Work Phone:** ____________ **Email:** ____________

Supervisor's Name: ____________ **Work Phone:** ____________ **Email:** ____________

INCIDENT INFORMATION

Date of Injury: ________ **Time:** ________ ☐ **AM** ☐ **PM** **Was Care 24 called?** ☐ Yes ☐ No

Date Reported: ________ **Time:** ________ ☐ **AM** ☐ **PM** **To Whom was it Reported:** ____________

Did you miss time from work? ☐ Yes ☐ No **If yes, List Dates:** ____________

Have you returned to work? ☐ Yes ☐ No **Date Returned:** ____________

Where did the injury take place? ______________________

Machine, tool, or object causing injury or illness: ______________________

Describe, in detail, how injury or illness occurred:

MEDICAL CARE INFORMATION

Were you treated for the injury? ☐ Yes ☐ No **What was the treatment?** ____________

Were you treated at a Medical Facility? ☐ Yes ☐ No **Did you require EMS transport?** ☐ Yes ☐ No

Name of Facility you were initially treated: ______________________

Please list the Primary Care Physician and any other Medical Providers providing follow-up treatment for this injury:

____

Did you aggravate a previous wound or condition? ☐ Yes ☐ No

If yes, please explain: ______________________

Have you had any previous workers' compensation claims? ☐ Yes ☐ No

If yes, please list: **Date:** ________ **Injury:** ______________________

Date: ________ **Injury:** ______________________

Date: ________ **Injury:** ______________________

NATURE OF INJURY OR ILLNESS *(Please Check Appropriate Box)*			
☐ Allergic Reaction	☐ Contusion/Bruise	☐ Heart Attack	☐ Puncture
☐ Bite/Sting	☐ Dislocation	☐ Heat Stroke	☐ Severance/Amputation
☐ Body Fluid Exposure	☐ Electric Shock	☐ Inflammation/Swelling	☐ Sprain/Tear
☐ Burn	☐ Fall/Slip	☐ Laceration/Cut	☐ Other
☐ Concussion/Head Injury	☐ Fracture/Broken Bone	☐ Poisoning	

PART OF BODY INJURED *(Please Check Appropriate Box)*			
☐ Abdomen ☐ L ☐ R	☐ Eye ☐ L ☐ R	☐ Knee ☐ L ☐ R	☐ TŜŜűK ☐ L ☐ R
☐ Ankle ☐ L ☐ R	☐ Face ☐ L ☐ R	☐ Mouth ☐ L ☐ R	☐ TK⅄∃K ☐ [☐ R
☐ Arm ☐ L ☐ R	☐ Finger ☐ L ☐ R	☐ Neck ☐ L ☐ R	☐ Thumb ☐ L ☐ R
☐ Back ☐ L ☐ R	☐ Foot ☐ L ☐ R	☐ Nose ☐ L ☐ R	☐ Toe ☐ L ☐ R
☐ Calf ☐ L ☐ R	☐ Groin ☐ L ☐ R	☐ Rib ☐ L ☐ R	☐ Wrist ☐ L ☐ R
☐ Chest ☐ L ☐ R	☐ Hand ☐ L ☐ R	☐ Shoulder ☐ L ☐ R	
☐ Ear ☐ L ☐ R	☐ Head ☐ L ☐ R	☐ Stomach ☐ L ☐ R	
☐ Elbow ☐ L ☐ R	☐ Hip ☐ L ☐ R	☐ Tailbone	

WITNESS INFORMATION

Name: _____ **Home or Cell Phone:** _____ **Work Phone:** _____

Name: _____ **Home or Cell Phone:** _____ **Work Phone:** _____

SIGNATURES

The above information is true to the best of my knowledge.

_____ _____ _____

Employee's Signature **Printed Name** **Date**

I have reviewed for completeness and not concurrence.

_____ _____ _____

Supervisor's Signature **Printed Name** **Date**

PLEASE SUBMIT THIS DOCUMENT AND RELATED BILLS TO PMA BY MAIL, FAX, OR EMAIL

Mail:
PMA Customer Service Center
PO Box 5231
Janesville, WI 53547-5231

Fax:
800-432-9762

Email:
ClaimsMail@pmagroup.com
(Include the Employee's Name & Date of Injury in the Subject Line)