County of Henrico, Department of Finance, Risk Management Division

WORKERS' COMPENSATION EMPLOYEE'S REPORT OF INJURY

Refer to Workers' Compensation Reporting Flowchart for additional information.

EMPLOYEE INFORMATION

Full Name: _____ Position: _____

Division/School/Station: _____ Shift: _____

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 all that apply.)

◯ Face/Head	◯ Nose	◯ Mouth	◯ Teeth
◯ Left Eye	◯ Right Eye	◯ Left Ear	◯ Right Ear
◯ Neck/Throat	◯ Upper Back	◯ Mid Back	◯ Lower Back
◯ Chest	◯ Abdomen	◯ Groin/Pelvis	◯ Buttocks/Tailbone
◯ 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	◯ 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 (Check all that apply.)

◯ Amputation	◯ Bite/Sting	◯ Bruise/Contusion	◯ Burn
◯ Concussion	◯ Cut/Laceration/Puncture	◯ Dislocation	◯ Electric Shock
◯ Exposure (Bodily Fluid)	◯ Exposure (Environmental)	◯ 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 miss time from work? ◯ YES ◯ NO If yes, Date(s) missed: _____

Have you returned to work? ◯ YES ◯ NO If yes, Date returned: _____ ◯ REGULAR DUTY (NO RESTRICTIONS) ◯ RESTRICTED DUTY

Did you aggravate a previous injury/condition? ◯ YES ◯ NO If yes, explain below.

Have you had any previous workers' compensation claims? ◯ YES ◯ NO If yes, list date and type of injury below .

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 LODESTAR WITHIN 24 HRS OR NEXT BUSINESS DAY.

MAIL
Lodestar
PO Box 4314
Clinton, IA 52733-4301

FAX
877-374-0936

EMAIL
CLAIMSMAIL@LODESTAR.COM
Include the Employee's Name & Date of Injury in the Subject Line