County of Henrico, Department of Finance, Risk Management Division

WORKERS' COMPENSATION SUPERVISOR'S INVESTIGATION REPORT

Refer to Workplace Injuries/Illnesses Reporting Flowchart for additional information.

INJURED EMPLOYEE INFORMATION

Full Name: _____ Position: _____

Division/School/Station: _____ Shift: _____

ACCIDENT INFORMATION

Date Reported: _____ To Whom: _____

Was CARE24 Called? ◯ YES ◯ NO (If NO, please call CARE 24 at 855-954-0866 and select option 2 to report injury.)

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

Location of Injury: _____

Police Report Number: _____

Was there a fatality? ◯ YES ◯ NO Was there an amputation or loss of eye? ◯ YES ◯ NO

Did Employee require EMS transport? ◯ YES ◯ NO Was Employee hospitalized? ◯ YES ◯ NO

If YES, Name of Hospital: _____

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

Was there a safety violation? ◯ YES ◯ NO If Yes, Describe:

Supervisor Comments/Recommendations:

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

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

SUPERVISOR INFORMATION

Name: _____ Email: _____

Work Phone: _____ Work Cell: _____

SIGNATURES

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