EASTERN VIRGINIA MEDICAL SCHOOL
EMPLOYEE'S REPORT OF INJURY

Part I. Employee Information

Department of School	Department or School Section	Name of Supervisor

Name of Injured: _____

Last First Middle Initial

Injured's Address: _____

Street City State Zip Code

Telephone numbers: (Day Time)_____ (Home)_____

Date of Injury:	Time of Injury: (Circle one) _____ a.m. p.m.

Part II. Part of Body Injured (Mark an "X" next to each body part injured. Circle right R or left L as appropriate.)

( ) Abdomen L R	( ) Chest L R	( ) Finger L R	( ) Hip L R	( ) Rib L R	( ) Thumb L R
( ) Ankle L R	( ) Ear L R	( ) Foot L R	( ) Knee L R	( ) Shoulder L R	( ) Toe L R
( )Arm L R	( ) Elbow L R	( ) Groin L R	( ) Mouth L R	( ) Stomach L R	( ) Wrist L R
( ) Back L R	( ) Eye L R	( ) Hand L R	( ) Neck L R	( ) Tailbone L R	
( ) Calf L R	( ) Face L R	( ) Head L R	( ) Nose L R	( ) Thigh L R	

Part III. Nature of Injury or Illness

( ) Abrasion	( ) Bite/Sting	( ) Burn	( ) Heart Attack	( ) Puncture	( ) Dislocation
( ) Allergic Reaction	( ) Blister	( ) Fall/Slip	( ) Heat Stroke	( ) Sprain/Strain	( ) Concussion
( ) Amputation	( ) Bruise	( ) Fracture	( ) Laceration	( ) Swelling	( ) Other

Describe in detail how you were injured:

Part IV. Accident Location (Describe where the injury occurred.)

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Part V. Medical History

Did the injured aggravate a previous wound or condition? Yes___ No___ If yes, list injury and treating physician.

Have you had any prior workers' compensation claims? Yes ____ No _____ If yes, when and how many?

Part VI. Witnesses (Use additional pages if necessary) (Do not include students):

Name:

Last First Middle Initial

Home Address:

Street City State Zip Code

Telephone Numbers:

(Home) _____ (Work) _____

Part VII. Group Health Physicians (List all of your group health physicians)

Part VIII. Signature

Print Name of Employee Last First Middle Initial	**Signature of Employee**. The above information Is true to the best of my knowledge.	
Department:	Telephone Number:	Date:

NOTE: This form must be forwarded to the Human Resources Department within **ONE** business day of discovery of the incident.

EASTERN VIRGINIA MEDICAL SCHOOL
WORKER'S COMPENSATION SUPERVISOR'S INVESTIGATION REPORT

Part I. Employee Information		
Department of School	Department or School Section	Name of Supervisor
Name of Injured: _____ Last First Middle Initial		
Part II. Injury Information		
Date of Injury	Time of Injury	Date Injury Reported
Where did the injury occur? (Be specific, give exact location):		
Part III. Supervisor's Information		
Do you agree with the employee's version of how the injury occurred? _____Yes _____No If no, fully describe your version fully:		
Part IV. Signature		
Printed Name of Supervisor	Signature of Supervisor	Date

NOTE: This form must be forwarded to the Human Resources Department within **ONE** business day of discovery of the incident.

EASTERN VIRGINIA MEDICAL SCHOOL
EMPLOYEE'S REPORT OF INJURY

Part I. Employee Information		
Employee Name:	Injury Date:	Today's Date:
Department of School	Name of Supervisor	Supervisor's Phone Number:

Part II. To Be Completed by Physician Only
Complaint(s)/Diagnosis: (Include Part of Body Involved – Left/Right, Upper/Lower)
Patient May Return to Work: _____Regular _____Restricted _____ (Date: _____)

Part III. Patient Restrictions
A. Length of Restriction: (Number of Days) _____ B. Describe Work Restrictions:
C. Medication Prescribed:
D. Does medication prevent patient from working on or around moving equipment, machinery, driving? Yes _____ No_____ If the answer to question D is yes, explain:
E. Date of Follow-up Appointment:

Part IV. Referral (If patient is referred to another physician, complete the next line)	
Date of Appointment:	Physician's Name:

Part V. Treatment Facility		
Name of Treatment Facility:	Address of Treatment Facility:	
Printed Name of Physician:	Signature of Physician:	Date

Submit bills: Eastern Virginia Medical School
Attention Human Resources
358 Mowbray Arch, Suite 101
Norfolk, VA 23507
(757)446-6043