

PLEASE PROVIDE THE OFFICE OF HUMAN RESOURCES WITH THE FOLLOWING INFORMATION CONCERNING YOUR **AT WORK OR WORK-RELATED ACCIDENT/INJURY**. (PLEASE PRINT)
BE SPECIFIC - COMPLETE EACH SECTION – ANSWER ALL (YES/NO) QUESTIONS

NAME: _____ UIN: _____

HOME ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

MARITAL STATUS: S M D W ACCIDENT/INJURY - **DATE/TIME** (am or pm) and **LOCATION**:

DATE: _____ **TIME:** _____ **LOCATION:** _____

HOW DID THE ACCIDENT/INJURY OCCUR, WHAT CAUSED THE ACCIDENT/INJURY (INCLUDE WORK FUNCTION YOU WERE PERFORMING): **Be specific, give details. Use the reverse if more space required.**

DESCRIBE YOUR INJURY (**PARTICULAR PART(S) OF BODY - RIGHT/LEFT**): _____

NAME OF WITNESS TO ACCIDENT/INJURY: _____

SUPERVISOR'S NAME & DATE NOTIFIED: _____

TIME LOST FROM WORK - YES/NO - **IF YES, Use a Manual Timesheet (see time reporting on the next page):**

DATE & TIME OUT: _____ DATE & TIME RETURNED: _____

MEDICAL ATTENTION REQUIRED - **YES/NO – YOU MUST SELECT AND ONLY USE A PANEL PHYSICIAN FROM THE BELOW** (see next page for more information) **CIRCLE YOUR SELECTION**

Dr. Frank Westmeyer
Patient Choice – Ghent

Dr. Glenn McDermott
Doctors on Call

Dr. Anthony Russo
SMG – Little Creek Medical Assoc.

By signing this form, I release all medical information to Old Dominion University and Managed Care Innovations. All information will be considered confidential and used only in the matter of the workers' compensation claim.

I certify that this accident/injury occurred at work or during a work-related function and that the above information is true and correct to the best of my knowledge and that I understand that submission of a false statement, report or claim could result in disciplinary action, penalties and/or termination of employment.

INJURED EMPLOYEE'S SIGNATURE & DATE: _____

I am aware of this at work/work related accident/injury. _____

SUPERVISOR'S SIGNATURE & DATE

OLD DOMINION UNIVERSITY - WORKERS' COMPENSATION PANEL PHYSICIAN INFORMATION

Virginia Workers' Compensation law requires your employer to provide to you a Panel of at least three physicians. You must select a physician from the Panel to treat your work related injury, even if you do not intend to seek immediate medical treatment. ***If you do not select and use one of the Panel Physicians from the list below for your work-related injury, you may be responsible for the cost of the medical care.***

Select and use one of the Panel Physicians below by circling the doctor's name on the accident/injury report. For your workers' compensation injury; you may not use another physician/health care provider, unless referred by your Panel Physician or change physicians without first consulting with the Human Resources Workers' Compensation office. If your Panel Physician determines you need additional or specialist treatment, the Panel Physician may refer you to another health care provider for this treatment. Lost time from work as a result of your work related injury must be authorized by your Panel Physician or a doctor/health care provider you are referred to by your Panel Physician.

Appointments are not required

Dr. Frank Westmeyer, Patient Choice – Ghent, 957 W. 21st St., Norfolk, VA 23517, Ph: 622-8358

Dr. Glenn McDermott, Doctors on Call, 1368 N. Great Neck Rd., VA Beach, VA 23454, Ph: 495-5003

Dr. Anthony Russo, Little Creek Medical Assoc., 1326 E. Little Creek Rd, Norfolk, VA 23518, Ph: 583-6338

OLD DOMINION UNIVERSITY - EMPLOYEE INFORMATION ON WORKERS' COMPENSATION

Medical expenses for work related injuries are payable, provided a claim has been filed within the required time frame and the insurance carrier accepts your claim and determines the accident/injury falls within the parameters of "arising out of and in the course of employment". If your panel physician certifies that you are unable to work at all, and the claim is determined to be compensable, you may be eligible for temporary disability benefits. These benefits are equal to two-thirds of your average weekly wage to the maximum set by law. Benefits may continue for a total of 500 weeks.

Even if you have already received benefits from your employer or insurer, **you must file a claim with the Virginia Workers' Compensation Commission (VWCC), 1000 DMV Drive, Richmond, VA 23222 in order to protect your right to benefits under Virginia Law. You may contact the VWCC at (804) 367-8600.** You must file a claim with the VWCC within two (2) years of your work-related accident/injury. **It's important and you are encouraged to obtain a VWCC Form #5 and brochure entitled "A Brief Guide to Workers' Compensation for Employees". You can get a form #5 and brochure by visiting Human Resources, by calling Human Resources at 757-683-3051, by calling the VWCC at 804-367-8600 or by visiting the VWCC website at www.vwc.state.va.us.**

Manual Timesheet Reporting

You are required to submit to your supervisor panel physician certification for any absences due to your work-related accident/injury or occupational disease. Report all absences/time lost from work, which are the result of your work-related accident/injury as Workers' Compensation Leave using a Classified Exempt or Non-Exempt Manual Timesheet available on the Office of Finance, Payroll forms page. Use a Manual Timesheet in place of on-line reporting (WTE) for the pay period in which the WC Leave is reported. Do not use a Manual Timesheet and report your time on-line (WTE). Your absence will initially be charged as Sick Leave, after a certification decision on your accident/injury has been made, Human Resources will take the necessary action to record your absence as WC Leave or Sick Leave, as appropriate.

I certify that I understand the importance of the contents of this document and that I have or soon will read this document. I understand that submission of a false statement, report or claim could result in disciplinary action, penalties and/or termination of employment.

Date: _____ Employee's signature: _____

RETURN COMPLETED FORMS TO AND CONTACT HUMAN RESOURCES/WORKERS' COMPENSATION. IF YOU HAVE ANY QUESTIONS - (757) 683-3051, FAX (757) 683-3064 or e-mail chollem@odu.edu.

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