First Report of Injury

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond Virginia 23220
1-877-664-2566

SEE INSTRUCTIONS ON REVERSE SIDE

www.vwc.state.va.us

Reason for Filling: _____
VWC Jurisdiction Claim #: (If assigned) _____

Claim Administrator File #: _____

Employer

Employer's Legal Name	Federal Employer Identification Number (FEIN)
Employer's Mailing Address	
Name/FEIN of Entity on Policy	Nature of Business
Name and Address of Insurer or Self-Insurer for this Claim	Policy Number

Time and Place of Accident

Location where accident occurred	Date of injury / /	Hour of injury ☐ a.m. ☐ p.m.	Date of Disability
Date injury or illness reported	If fatal, give date of death	If fatal, give marital status ☐ Single ☐ Divorced ☐ Married ☐ Widowed	
Was Employee paid in full for day of injury ☐ Yes ☐ No	If fatal, give number of dependent children		

Injured Worker

Name of Injured Worker	Phone Number ( ) -	Injured Worker ID Number
Injured Worker's mailing address	Date of Birth Wages ☐ Hour ☐ Day ☐ Week ☐ Other	Type of ID ☐ Social Security No. ☐ Employment Visa ☐ Green Card ☐ Passport No. ☐ Unknown
Occupation at time of injury or illness	Date of Hire	Sex ☐ Male ☐ Female

Nature and Cause of Accident

Machine, tool, or object causing injury or illness		
Describe fully how injury or illness occurred:		
Describe nature of injury, occupational disease, or illness, including body parts affected		Treated in Emergency Room ☐ Yes ☐ No
Hospital or Clinic	Physician	
Has Employee Returned to Work? ☐ Yes ☐ No	If Yes, On What Date?	Was Salary Continued? ☐ Yes ☐ No

Signatures

Submitter (name, signature, title)	Date	Phone number
Submitter's Address		

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VWC Form #3
Rev. 10/08