Employer's Accident Report

(formerly: Employer's First Report of Accident)
Virginia Workers' Compensation Commission
1000 DMV Drive Richmond VA 23220
See instructions on the reverse of this form

The boxes to the right are for the use of the insurer	Reason for filing	VWC file number
	Insurer code or PEO Ref. No.	Insurer location
	Insurer claim number	

Employer

1. Name of employer (trading as or doing business as, if applicable)	2. Federal Tax Identification Number	3. Employer's Case No. (if applicable)
Old Dominion University Research Foundation	54-6068198	
4. Mailing address P. O. Box 6369 Norfolk. VA 23508	5. Location (if different from mailing address)	
6. Parent corporation /Policy Named Insured (if applicable) or PEO name	7. Nature of business (NAICS code, if applicable)	
8. Name and Address of Insurer or self-insurer for this claim St. Paul Traveler's	9. Policy number PHUB194OC57907	10. Effective date 10/25/2007

Time and Place of Accident

11. City or county where accident occurred	12. Date of injury	13. Hour of injury ☐ a.m. ☐ p.m 13a. Time began work ☐ a.m. ☐ p.m	14. Date of incapacity	15. Hour of incapacity
16. Was employee paid in full for day of injury? ☐ Yes ☐ No		17. Was employee paid in full for day incapacity began? ☐ Yes ☐ No		
18. Date injury or illness reported	19. Person to whom reported	20. Name of other witness	21. If fatal, give date of death	

Employee

22. Name of employee (Last, First, Middle)		23. Phone number	24. Sex ☐ Male ☐ Female
25. Address		26. Date of birth 28. Social security number	27. Marital status ☐ Single ☐ Divorced ☐ Married ☐ Widowed
29. Occupation at time of injury or illness (SOC code, if applicable)		30. Is worker covered by PEO policy? ☐ Yes ☐ No	31. Number of dependent children ☐
32. How long in current job?	33.Date of Hire	34. Was employee paid on a piece work or hourly basis? ☐ Piece work ☐ Hourly	
35. Hours worked per day ☐	36. Days worked per week ☐	37. Value of perquisites per week Food/meals $ Lodging $ Tips $ Other $	
38. Wages per hour $	39. Earnings per week (inc. overtime) $		

Nature and Cause of Accident

40. Machine, tool, or object causing injury or illness	41. Specify part of machine, etc.
42. Describe fully how injury or illness occurred	
43. Describe nature of injury or illness, including parts of body affected	43a. Overnight inpatient hospitalization? ☐ Yes ☐ No 43b. Treated in Emergency Room? ☐ Yes ☐ No
44. Physician (name and address)	45. Hospital or Clinic (name and address)

46. Probable length of disability	47. Has employee returned to work? ☐ Yes ☐ No	If yes 48. At what wage?	49. On what date?
50. EMPLOYER: prepared by (name, signature, title)		51. Date	52. Phone number
53. INSURER: (name of processor)		54. Date	55. Phone number
56. THIRD PARTY ADMINISTRATOR (if applicable)	57. Address		58. Phone number

This report is required by the Virginia Workers' Compensation Act

FILING INSTRUCTIONS

(Instructions Updated 09/01/07)

Employer's Accident Report
VWC Form No. 3

This form must be completed by the employer, the employer's representative or the insurer and filed within 10 days after the notice of a work-related injury, occupational illness/disease or if the occurrence resulted in death to the worker. If the employer or its representative completed the form, the form should be submitted to the insurer who provided insurance coverage on the date of the occurrence, and the insurer will immediately file the original and one copy of the completed form with the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220. The additional copy of the Employer's Accident Report (VWC Form No. 3) will be furnished to the Virginia Department of Labor and Industry. The filing of this form with the Commission is a requirement under §65.2-900 of the Act.

Employer

1. As the employer, you are responsible for accurately completing all sections of this form when one of your employees is injured. It should be typed or legibly printed, signed, and dated by the preparer. Your insurance carrier, claims servicing agency, self-insured employer's representative or third-party administrator should complete the information in the top right corner.
2. The "trading as" or "doing business" as name should appear in Block l and the Parent Corporation (policy named insured) should be reflected in Block 6.
3. Provide the insurance information (name, address, policy number, and effective date of the policy), that covers the date that the work-related accident or occupational illness or disease occurred, in Blocks 8, 9 and 10.
4. As the employer, if you are subject to OSHA record-keeping requirements, a copy of this completed form may be retained as a supplementary record of an occupational illness or disease. Use Block 3 (Employer's Case No.) to cross-reference any master-log of work-related accidents, illnesses, diseases and death claims.
5. Send the original beige form to your insurance carrier, claims servicing agency, or third-party administrator for processing.

Insurance Companies, Self-Insurers, Servicing Companies, Authorized Representatives, Third-Party Administrators (TPA's), Group Self-Insurance Associations, and Professional Employer Organizations (PEO's):

1. The insurer should provide the information at the top right of the form. Use a numerical code (1-7) to indicate the reason for filing the form for accidents meeting one of the filing criteria's*. When using a code reason (7) provide the VWC file number. Note that the insurer code refers to the five-digit numeric code assigned by the National Counsel on Compensation Insurance (NCCI). The Virginia Workers' Compensation Commission assigns self-insured employers a similar five-digit code number. Professional Employer Organizations (PEO's) must use the VWC reference number.
2. If the work-related accident or occupational illness or disease does not meet one of the filing criteria*, a Report of Minor Injuries (VWC Form 45-A) should be completed for the occurrence and timely filed with the Virginia Workers' Compensation Commission.
3. Verify the insurance information that was provided by the employer (name, address, policy number, and effective date of the policy) as it appears on this form and ensure that it covers the date that the accident or occupational illness or disease occurred (Blocks 8, 9 and 10).
4. Provide the applicable information requested in Blocks 50 through 58 as it applies.

Forms: Additional copies of this form are available without cost by writing to the Commission. Address your inquiries to "Forms" at the listed Virginia Workers' Compensation Commission address. This form is also available on the Commission's website, at www.vwc.state.va.us. ***Note:*** color-coding of the forms greatly increases the Commission's efficiency in processing claims, and that any alternative versions of the form you develop yourself require prior approval by the Commission. The original copy of the Employer's Accident Report (VWC Form No. 3) should be on beige paper.

Electronic Filing: The Employer's Accident Report (VWC Form No. 3) can be filed electronically through the Commission's Website, at www.vwc.state.va.us. For questions or assistance regarding the electronic filing process, please contact our "Information Systems Department" at (804) 367-2254 or in writing. Also, provide a brief description of your current data processing and communication capabilities.

For questions or assistance with completing the form, please contact the First Report's Unit at (804) 367-0072 or the Commission's Toll-free number at (1-877) 664-2566.

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*The criteria's for filing are (1) lost time exceeds seven days, (2) medical expenses exceed $1,000, (3) compensability is denied, (4) issues are disputed, (5) accident resulted in death, (6) permanent disability or disfigurement may be involved, and (7) a specific request is made by the Virginia Workers' Compensation Commission.