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 filing: _____
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 injury or illness reported	If fatal, give date of death If fatal, give number of dependent children	If fatal, give marital status ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Injured Worker

Name of Injured Worker	Phone Number	Injured Worker ID Number
Injured Worker's mailing address		Type of ID ☐ Social Security No. ☐ Employment Visa ☐ Green Card ☐ Passport No. ☐ Unknown
Occupation at time of injury or illness	Date of birth	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

Signatures

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

First Report of Injury

Filing Instructions

The Virginia Workers' Compensation Act requires that **ALL** injuries occurring in the course of employment be reported to the Commission pursuant to Va. Code §65.2-900.

Employer

The employer is responsible for accurately completing all sections of this form when an employee is injured. It should be typed or legibly printed, signed, and dated by the preparer. Send the original form to the claim administrator for the insurance company who provided insurance coverage on the date of the occurrence. The claim administrator will report this information to the Commission. Contact your workers' compensation insurance provider for additional information.

Claim Administrator

Claim administrators who are EDI enabled will use the information contained on the paper form and submit electronic data to the Commission.

Claim administrators who are NOT EDI enabled must immediately file the completed form with the Commission. Please note: EDI is mandatory no later than June 30, 2009, after which time paper reports will no longer be accepted. Until you are in EDI production, mail the completed form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220. At the top of the form, use a numerical code (1-7) to indicate the reason for filing the form for accidents meeting one of the filing criterion.* If none of the criteria apply, you must still report the accident, but may use either Form 45A or this form to do so. (Leave "reason for filing" blank in such a case.)

For questions or assistance in completing the form, please contact the Commission toll-free at 877-664-2566.

*Criteria for filing are: (1) lost time exceeds seven days; (2) medical expenses exceed $1,000.00; (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.

Claim Form

Access your claim online: webfile.workcomp.virginia.gov

Virginia Workers' Compensation Commission

Jurisdiction Claim Number (JCN)

Claim Administrator Number

Injured Worker Information			Employer Information		
Name			Name of Company		
Address			Address		
City	State	Zip Code	City	State	Zip Code
Primary Phone	Gross Weekly Earnings		Employer's Phone		

Injury

Date of Injury*	Where Injury Occurred (City or County)	Parts of Body Injured

How Injury Occurred

***If claiming an occupational disease** (use separate claim form for Coal Workers' Pneumoconiosis)**:**

Name of Occupational Disease	Date last worked for employer	Date doctor stated the disease was caused by work

Request for Benefits

I need assistance obtaining the following benefits. If the benefits are denied, this form will serve as a hearing request.

☐ Lifetime Medical Award (coverage for related medical expenses).

☐ Wage Loss Replacement (Temporary Total Disability - Completely out of work):

From: _____ To: _____ ☐ continuing From: _____ To: _____ ☐ continuing

☐ Wage Loss Replacement (Temporary Partial Disability - Partially out of work/light duty):

From: _____ To: _____ ☐ continuing From: _____ To: _____ ☐ continuing

☐ Compensation for Permanent Loss (Permanent Partial Disability):

☐ Loss of use of a body part ☐ Disfigurement/Scarring ☐ Amputation ☐ Hearing/Vision loss ☐ Lung disease

☐ Payment/reimbursement for the following expenses (attach medical records, itemized bills, receipts, or mileage log):

☐ Medical bills ☐ Mileage/Transportation ☐ Prescriptions

☐ Death benefits to dependents and/or funeral expenses.

☐ Other: _____

Signature

I hereby file this claim to protect my right to benefits under the Virginia Workers' Compensation Act for the injury or disease described above.

SIGNATURE (Required) PRINT DATE

Claim Form Process & Instructions

Injury

When an individual has experienced an injury or an occupational disease in the workplace, it is important to give immediate notice to the employer about the injury. Employers are required to file a First Report of Injury (FROI) within ten (10) days of having knowledge of any injury.

Ombudsman Office

Have questions about the Virginia Workers' Compensation Commission and no lawyer? Call the Ombuds Department at 833-448-1681, or email ombuds@workcomp.virginia.gov. We cannot give legal advice, but all conversations will be kept confidential.

Claim Form

Pursuant to Va. Code §65.2-601, a claim for specific benefits must be filed within two (2) years from the date of injury. Even if the Claim Administrator is voluntarily paying benefits, rights are not protected unless there is an Award Order.

Award Order

If the Claim Administrator accepts the claim, an Award Agreement is sent to the injured worker. Once signed by all parties, the Award Agreement must be filed with the Commission for entry of the Award Order. An Award Order protects the injured worker's rights to benefits.

Alternative Dispute Resolution (ADR)

Mediation is a voluntary and confidential informal dispute resolution process where a neutral third party (mediator) facilitates communication to assist the parties in mediating an agreeable solution. The purpose of mediation is to identify issues, clarify misunderstandings, explore solutions and mediate an agreement. For further information, contact the ADR Department at 804-205-3139.

Hearing

A hearing may be necessary to resolve disputed issues. A completed Claim Form and medical records* to support the claim must be filed for this to occur. The primary objective is to hear and decide disputed claims and issues arising under the Virginia Workers' Compensation Act in a prompt, fair and impartial manner.

*Medical Records & Subpoenas

Copies of medical records may be obtained from the physician. However, if copies of medical records and/or bills cannot be obtained, a subpoena can be requested by sending the name and address of the medical provider to the Clerk of the Commission. A $12 money order made payable to the Sheriff of the city or county where the medical provider is located must be included for each subpoena.

Benefits Covered under the Virginia Workers' Compensation Act

- **Lifetime Medical** - payment for medical treatment/expenses for the injury or occupational disease, now and in the future.
- **Temporary Total Disability -** wage loss replacement while completely out of work. Must be medically authorized.
- **Temporary Partial Disability -** wage loss replacement while partially out of work, or working light duty. Must be medically authorized.
- **Permanent Partial Disability -** compensation for loss of use of a body part, amputation, disfigurement/bodily scarring, loss of hearing, loss of vision or lung disease. Must be medically supported.
- **Medical Expenses -** payment/reimbursement of medical bills, or out of pocket expenses, such as prescription and mileage/transportation. Must provide bills, receipts and/or mileage logs.
- **Death Benefits -** payment/reimbursement of funeral/transportation expenses or wage loss replacement for surviving spouse, children, or certain other dependents. Death Certificate, Marriage License and/or Birth Certificate(s) must be provided.
- **Other -** benefits not previously mentioned (vocational rehabilitation, specific medical treatment/procedure, panel of physicians, etc).

Wage Chart

Employer's Statement of Wage Earnings

Virginia Workers' Compensation Commission
333 E. Franklin St., Richmond, Virginia 23219

The boxes to the right are for the use of the insurer.	Reserved	VWC File Number
	Insurer Claim Number	

	Employee		**Address**	
Name of Employee			Date of Accident	Date of Hire
	Employer		**Address**	
Name of Employer				

PLEASE REFER TO THE FILING INSTRUCTIONS PRINTED ON THE BACK OF THIS FORM

Week No.	Week Ending Date	Days Worked	Gross amount paid, including overtime	Week No.	Week Ending Date	Days Worked	Gross amount paid, including overtime	Week No.	Week Ending Date	Days Worked	Gross amount paid, including overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35							
18				36							

Value of perquisites for entire year:

Total gross earning $_____ Total weeks worked _____

Bonuses $_____ Electricity $_____
Meals/Lodging $_____ Water $_____
Meals Only $_____ Telephone $_____
Temporary Lodging $_____ Uniforms $_____
House Rent $_____ Laundry $_____
Tip Income $_____

Total value of perquisites $_____

Total earnings & perquisites $_____

VWC use only:

AWW:_____
CR: _____

INSURER OR EMPLOYER (include name & signature)	Date	Telephone number

Wage Chart
VWC Form No. 7A (rev. 11-21)

FILING INSTRUCTIONS

Wage Chart
VWC Form No. 7A

How to complete the Wage Chart:

□ Indicate gross weekly earnings for the 52 weekly periods immediately **preceding** the date of accident.

□ Note that these earnings are GROSS earnings and include overtime and tips, before any deductions are made for taxes or Social Security. If there were any perquisites, please list the TOTAL value separately at the bottom of the chart.

□ If an injured employee lost more than seven consecutive calendar days, although not in the same week, these periods should be noted on the Wage Chart (VWC Form No. 7-A) using an asterisk in the Week No. column and are not to be counted in the calculations. Va. Code § 65.2-101.

□ If injured employee has worked less than 12 months, the earnings for the time worked should be used. The earnings for a similar employee may be used if the employee has worked less than 60 days.

How to calculate the Wage Chart:

- If a full year's wage information **has been** provided covering the 52 week period prior to the date of accident:

  - determine the total wages earned, including yearly perquisites;
  - divide the total wages earned for this period by 52;
  - the sum will be the average weekly wage.

- If a full year's wage information **has not been** provided covering the 52 week period prior to the date of accident:

  - determine the total wages earned, including yearly perquisites;
  - divide the total wages earned by the number of weeks wages were earned (Note: if warranted, the weeks can be converted into days and calculated on that basis);
  - the sum will be the average weekly wage.

- If the form is completed on a **bi-weekly basis:**

  - determine the total wages earned, including yearly perquisites;
  - divide the total wages earned by the number of weeks worked (employee paid 26 times a year represents 52 weeks of wages);
  - the sum will be the average weekly wage.

- Samples of properly completed wage chart(s) are available through the Commission's website at workcomp.virginia.gov under the forms menu.

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