University of Virginia
Facilities Management Department

Workers' Compensation Packet

Latest Revision September 2015

Employee Checklist for Workers' Compensation Claims

_____Report the accident to your supervisor immediately. Complete the accident report and submit to your supervisor. Failure to notify as soon as possible may result in denied claims.

_____Select a physician from the panel offered by your employer. Complete the form and submit to your supervisor. This required form must be completed even if you do not wish to seek medical attention.

_____Seek medical attention from the panel physician and submit any disability slips/doctor's notes to your supervisor and/or agency workers' compensation coordinator. You must obtain a doctor's note for EACH visit.

_____If your accident is an emergency, please seek medical treatment from the UVA Health System or Martha Jefferson emergency room. This is ONLY for the initial treatment, follow-up with a non-emergency Panel Physician from form.

_____ If you are a VSDP (Virginia Sickness and Disability Program) participant, call the VSDP provider (Reed Group) immediately to report the injury if the disability is anticipated to exceed 7 calendar days. The toll free number is 1-877-928-7021.

_____Communicate results of all medical appointments and return-to-work status with your supervisor and/or agency's workers' compensation coordinator.

_____Notify your supervisor of any return-to-work release and present your medical release to your supervisor and/or workers' compensation representative prior to reporting after missing time related to injury.

_____Cooperate with nurse consultants and return-to-work efforts.

_____Consult www.covwc.com to locate a participating pharmacy. A First Script Pharmacy form is located in the Facilities Management Workers Comp Packet. The First Script network includes all major pharmacy chains, grocery stores and many single location pharmacies. You must take the First Script Pharmacy form to a participating pharmacy.

Any questions, please contact Lisa Dennis for Facilities Management employees at lrd5w@virginia.edu or 434-989-0324 OR Linda Coiner at lgc3u@virginia.edu or 434-924-8939. FM Workers' Compensation Packet Forms are located on the FM website: *For FM employees - Frequently used Human Resources Forms* at http://www.fm.virginia.edu/employees/hrforms.html and the FM-OHS webpage at http://www.fm.virginia.edu/depts/safety.html#sresources.

Facilities Management
Workers' Compensation Information

INSTRUCTIONS for the SUPERVISOR

IMPORTANT NOTE: If employee does not require (or refuses) medical treatment, the injury must still be reported according to the following procedures.

1. Offer medical treatment to the employee and present the injured employee with the **UVa's Workers' Compensation Attending Physician Panel** Form. **(NOTE: <u>It is state law that the employee sign, date and initial this form even if they do not seek medical treatment. If the employee refuses, the Supervisor must make a note on the form, sign and date the form and submit it with the FM Accident Report Form.)</u>**

2. Immediately report the injury to the **Facilities Management Occupational Health & Safety Department,** Lisa Dennis at 989-0324 or Brian Shifflett at 531-7203. Advise the FM Occupational Health & Safety Department of all updates and changes regarding the injured employee.

3. Assist the injured employee with completing the **University of Virginia Agency 207 - FM Accident Report for Workers' Compensation Claim** Form.

4. Complete the **Supervisors portion of the Workers' Compensation Supervisor's Accident Report** Form.

5. **Return the completed originals of the following:**

   - **Panel of Physicians** Form
   - **Accident Report for Workers' Compensation Claim** Form
   - All **Doctor's notes** (Including Return to Work Release)
   - **Workers' Compensation Supervisor's Accident Report** Form

   To:
   Lisa Dennis
   Facilities Management Occupational Health & Safety
   (Next to Recycling on Leake Drive)
   PO Box 400726
   Leake Building Charlottesville, VA 22904

6. Provide all subsequent information related to the employee's injury, absence, return-to-work, etc., to FM-Occupational Health and Safety immediately upon receipt.

University of Virginia Agency 207 Accident Report for Workers' Compensation Claim

UVA Facilities Management

INSTRUCTIONS: This form is to be completed by the injured employee and supervisor. Please submit completed documents to Lisa Dennis in the FM-Occupational Health and Safety Office (FM-OHS is next to Recycling). INCLUDE ALL DOCUMENTS: FM Accident Report Form, Completed Panel Physicians Form and all Doctors' Notes. If you need assistance please contact Lisa Dennis: (434) 989-0324 or email: lrd5w@virginia.edu. FM-OHS will enter information into the Worker's Compensation claim system and forward to the University Human Resources Workers' Compensation Coordinator. COMPLETE ALL INFORMATION & WRITE CLEARLY

Employee Information

First/Middle Initial/Last Name:_____

Employee Assignment Number: _____ **Employee UVA Email:** _____**@virginia.edu**

Home Address:_____ _____ _____
House#/ Apt#/ Street City and State Zip Code

Home Phone: _____**Work Phone:**_____**Cell Phone:** _____

Date of Birth: _____**Sex: Male or Female (Circle one) Marital Status:** _____

Department:_____ **Sub Agency Code: 207-**_____

Occupation: _____**Work hrs./day**_____**Date of Hire:** _____

Employee Type (please check): Classified _____ **University Staff** _____ **Hourly**_____ **Faculty** _____ **Seasonal** _____

Information about Time/Place of Injury

Exact Date of Injury: _____**Time of Injury:**_____ **AM or PM (Circle one)**

Exact Location (Bldg, Room#, Floor, Indoor, Outdoor): _____

Exact Date Accident Reported: _____**Reported Accident to:**_____

Was Supervisor Notified (please check) Yes___**No**___ **Supervisor Name:**_____

Start Time of Work Shift on date of injury: _____ **AM or PM (Circle one)**

Name of Witness(es)_____

Information about the Nature and Cause of Accident

Machine, tool, or object causing injury:_____

Nature of injury (broken bone, strain, burn):_____

Parts of body involved (list all):_____

*** For finger/thumb, hand, wrist, arm or shoulder injury: Are you Right-handed or Left-handed? (Circle one)**

Was safety equipment used: Yes____**No**____**If so, what kind (list all):**_____

Explain how the incident or injury occurred. Describe the sequence of events; specify object or exposure which directly produced the incident or injury: _____

_____

_____

_____

_____

_____

_____

Was Medical Treatment Provided: Yes ____ No____ Where: _____

Was time lost from work: Yes___No___If yes, how long:_____

Date Returned to Work:_____ **Did the doctor/nurse place you on a work restriction? Yes____ No____**

Employee Signature:_____**Date:**_____

(Falsification of records is a serious misconduct, which may result in discharge)

Supervisor in Charge at the Time of Accident (Please complete)

Was the employee doing something other than duties at the time of the accident: Yes_____ No_____

If yes, please explain: _____

_____

Did a non-University person contribute to the accident: Yes_____ No_____

If yes, please explain: _____

Give accident causes and comment fully: _____

_____

_____

Supervisors play an important role in providing safe work environments. What action is necessary to prevent reoccurrence of this type of accident: _____

_____

_____

Has corrective action been taken: Yes_____ No_____ If corrective actions require additional assistance, please contact FM-Occupational Health & Safety (FM-OHS) at 989-0324 or 531-7203.

Is Department able to accommodate injured employee's work restrictions: Yes_____ No_____

If yes, list start of restriction work date:_____ **If no, list last date employee worked:** _____

Supervisor's Signature:_____ **Date Signed:**_____

Phone Number:_____ **UVA Email:**_____**@virginia.edu**

Workers' Compensation Attending Physician Panel for University Academic Division Faculty and Staff

The University of Virginia is offering the following Attending Physician Panel in compliance with Section 65.2 of the Virginia Workers' Compensation Act. The below panel is to be used by faculty and staff in the University's Academic Division (Agency 207).

Injured Academic Division faculty and staff who have filed for Workers' Compensation benefits must choose one physician for treatment of claimed, work-related injuries. Failure to choose one of the physicians listed below may bar compensation benefits, including the cost of medical care. Employees' Primary Care Physicians are **not** authorized as attending physicians on UVa's Panel.

Panel of Physicians - **Panel physicians will make appropriate referrals to specialists.**

Dr. David Rubendall 434-243-0075
Dr. Darlinda Grice
UVA-WorkMed
1910 Arlington Blvd., Charlottesville

Dr. William G. Talbot 434-982-4200
First Med at Pantops
125 Riverbend Drive #3, Charlottesville

Dr. Shelly Dawson 434-978-3998
MedExpress
1149 Seminole Trail, Charlottesville
MedExpress 434-244-3027
260 Pantops Center, Charlottesville

Emergency Facilities for Initial Emergency Visit Only

UVA Health System Emergency Room 434-924-2231
Lee Street, Charlottesville

Martha Jefferson Emergency Room 434-654-7150
500 Martha Jefferson Drive, Charlottesville

I have been offered a choice of attending physicians from UVA's Workers' Compensation Panel and have chosen the following physician:_____

- or -

I have been offered a choice of attending physicians from UVA's Workers' Compensation Panel and have chosen the following physician:_____but have declined medical treatment at this time.

Employee Name: _____ Date: _____

Employee Signature: _____

Please initial: _____ I understand that I am responsible for any costs incurred in the event that Workers' Compensation denies my claim.

Updated 9/2015

PHARMACY: Commonwealth of Virginia participates in First Script, a pharmacy benefit program administered by **Medco**. Please call the First Script Help Desk, 24 hours a day, 7 days a week, at 1-800-791-2080 to verify employee eligibility. First Script claims are submitted electronically and electronic approval of the claim will be returned. ***You will not be required to submit any paperwork for this claim and payment is guaranteed for approved claims.***

Online Claim Information Claims are processed through the Medco network

Group #	FSNCVTY
BIN #	610014
PCN #	Not Applicable
Member ID#	First Script will provide Member ID# upon verification of eligibility

EMPLOYEE: First Script is valid only for medications prescribed for your work-related injury. You or your group health insurer, are financially responsible for any other prescriptions.

First Script is available at nearly 56,000 pharmacies nationwide. To locate a nearby pharmacy, please call First Script Customer Service at 1-800-791-2080.

Please present this form to your pharmacist along with your work related injury prescriptions.

Pharmacy Benefit Program

Commonwealth of Virginia

Employer Information Card

UNIVERSITY OF VIRGINIA

Agency Name

Agency Code CV207000

Questions? Call First Script Customer Service at 1-800-791-2080

EMPLOYEE: Please complete the information below before giving this form to your pharmacist.

Name

Social Security Number

Sub-Agency N/A