

Volunteer Injury Claim Reporting

1. **Seek appropriate emergency medical attention**
2. **Complete "Accident Verification Report Form" adopted by the SCFRA Safety Committee**
 - **Required Chief Officer's signature.**
3. **Complete workers compensation "Employers Accident Report" form.**
 - **Requires Chief Officer's or President's signature**
4. **Complete Provident's "First Notice of Claim" form.**
 - **Requires injured individual's signature**
 - **Requires Chief Officer's or President's signature**
5. **Forward all documents to:**

Shenvalley Insurance Agency, Inc.
P.O. Box 716
Mt. Jackson, VA 22842

Phone: 477-2515
Fax: 477-2516
6. **Direct insurance related questions to Kelly Stauff at Shenvalley Insurance Agency.**

ACCIDENT VERIFICATION REPORT FORM

THIS FORM SHALL BE SUBMITTED TO THE INSURANCE AGENT & SAFETY COMMITTEE IN THE EVENT OF ANY ACCIDENT THAT DAMAGES EQUIPMENT, VEHICLES, PRIVATE PROPERTY & OR RESULTS IN PERSONAL INJURY WHILE ENGAGED IN DEPARTMENTAL ACTIVITIES

1. ACCIDENT DETAILS:

DATE: _____

TIME: _____

PERSON'S / EQUIPMENT INVOLVED _____

LOCATION OF ACCIDENT _____

SITE OF INJURY _____

RESULT OF ACCIDENT _____

WITNESSES _____

OTHER PARTIES INVOLVED _____

OTHER INFORMATION:

DISCRIPTION OF ACCIDENT _____

IF MVA DRAW DETAIL _____

DIAGRAM ON BACK : _____

2. PREVENTABILITY OF THE ACCIDENT:

WAS THE ACCIDENT PREVENTABLE OR NONPREVENTABLE?

STATE REASONS WHY: _____

3. CORRECTIVE ACTION

HOW WILL YOU PREVENT A SIMILAR ACCIDENT FROM OCCURRING IN THE FUTURE?

PRINT NAME: _____

DATE: _____

SIGNATURE: _____

SIGNATURE CHIEF OFFICER: _____

AIC/OIC IN CHARGE _____

DATE: _____

IF MORE ROOM IS REQUIRED TO ANSWER ANY OF THE ABOVE QUESTIONS, PLEASE USE THE BACK OF THIS FORM

FAX TO 477-2516

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 insurer has the right to use the name 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)
4. Mailing address	5. Location (if different from mailing address)	
6. Parent corporation /Policy Named Insured (if applicable) or PEO name	7. Nature of business	
8. Name and Address of insurer or self-insurer for this claim	9. Policy number	10. Effective date

Time and Place of Accident				
11. City or county where accident occurred	12. Date of injury	13. Hour of injury <input type="text"/> a.m. <input type="text"/> p.m. 13a. Time began work <input type="text"/> a.m. <input type="text"/> p.m.	14. Date of incapacity	15. Hour of incapacity
16. Was employee paid in full for day of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. Was employee paid in full for day incapacity began? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female
25. Address	26. Date of birth	27. Marital status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed
	28. Social security number	
29. Occupation at time of injury or illness	30. Is worker covered by PEO policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	31. Number of dependent children <input type="text"/>
32. How long in current job?	33. Date of Hire	34. Was employee paid on a piece work or hourly basis? <input type="checkbox"/> Piece work <input type="checkbox"/> Hourly
35. Hours worked per day <input type="text"/>	36. Days worked per week <input type="text"/>	37. Value of perquisites per week Food/meals Lodging Tips Other \$ \$ \$ \$
38. Wages per hour \$ <input type="text"/>	39. Earnings per week (inc. overtime) \$ <input type="text"/>	

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? <input type="checkbox"/> Yes <input type="checkbox"/> No 43b. Treated in Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No
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44. Physician (name and address)	45. Hospital or Clinic (name and address)
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46. Probable length of disability	47. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes	48. At what wage?	49. On what date?
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50. EMPLOYER: prepared by (name, signature, title)	51. Date	52. Phone number
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53. INSURER: (name of processor)	54. Date	55. Phone number
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56. THIRD PARTY ADMINISTRATOR (if applicable)	57. Address	58. Phone number
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INSTRUCTIONS

Employer's Accident Report (formerly Employer's First Report of Accident) VWC Form No. 3

Employer

1. Fill out this form whenever one of your employees is injured. Provide all the information requested, except the information in the top right corner. Please type or print all information in black ink. Your signature is required on line 50 of the form.
2. Send the original beige form to your insurance carrier, claims servicing agency, or third party administrator for processing. If you are self-insured, send it to your organization's designated office for handling workers' compensation claims.
3. If you are an employer subject to OSHA record-keeping requirements, you may retain a copy of this completed form as a supplementary record of occupational injury or illness. Use block #3 (Employer's Case No.) to cross-reference your master log of accidents and illnesses.
4. If you need additional copies of this form, please request them from your insurance carrier, claims servicing agency, or third party administrator.

Insurance carriers, self-insured employers, Professional Employer Organizations (PEO's), and authorized representatives

1. For accidents meeting one of the seven criteria for establishing a Commission Case File,* submit the original beige form and one copy to the Virginia Workers' Compensation Commission at 1000 DMV Drive, Richmond VA 23220. The code for the reason for filing should be written at the top right of the form.
2. When processing these forms prior to transmittal to the Commission, please include the information requested at the top right of the form, verify that the carrier name and policy number given by the employer are accurate, and enter your name and phone number, and the date of processing at the bottom of the form.
3. Insurer code at the top right of the form refers to the five-digit code assigned by NCCI. If you are self-insured, it refers to a similar five-digit number assigned by the Virginia Workers' Compensation Commission. A PEO must use the VWCC reference number.
4. Additional copies of this form are available without cost by writing to the Commission. Please note that 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. Write to "Forms" at the listed Virginia Workers' Compensation Commission address.
5. On Lines 8 and 9, the employer or carrier is to give the name of the responsible carrier as set forth on the policy (line 8) and that carrier's policy number (line 9).

*The criteria 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.



Benefits for Emergency Service Organizations since 1928

FIRST NOTICE OF CLAIM

PROVIDENT AGENCY, INC.
 272 ALPHA DRIVE - P.O. BOX 11588
 PITTSBURGH, PA 15238
 TOLL-FREE: 800-447-0360
 PHONE: 412-963-1200
 FAX: 412-963-0415

Name		Date of Birth / /	Social Security Number
Address			Home Phone Number ()
What is your regular occupation?		Employed By (Name of Company)	
Employer's Address			Employer's Phone Number ()
Please enclose pay stubs or prior year Schedule Cs (self-employed).		Wages/Earnings: Hourly: Weekly:	Date Last Worked / /
Time of Accident AM PM	Date of Accident / /	Place of Accident	
What is your injury or illness?		How did it happen?	
Name and Address of Treating Physician		Name and Address of Hospital	
Did you lose any Time from Work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown at this time	Did you file with Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
I was totally disabled from / / to / /		Date you have or are expected to return to work / /	

I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I hereby authorize any physician, hospital, insurer, governmental agency, other organization or person having any records, data or other information concerning me to furnish such records, data or information as may be requested by Provident Life and Accident Insurance Company or its duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A copy of this authorization shall be considered as effective and valid as the original.

Date _____ 20 _____ Signed _____
(Claimant)

THIS SECTION TO BE COMPLETED BY AUTHORIZED MEMBER OF FIRE DEPARTMENT, RESCUE OR AMBULANCE SQUAD

<input type="checkbox"/> Yes	<input type="checkbox"/> No -- Claimant was a member of your organization at the time of injury or illness	Policy Number
<input type="checkbox"/> Yes	<input type="checkbox"/> No -- Claimant was engaged in an authorized activity at the time of injury or illness	
Name of Fire/Rescue/Ambulance Company/District or Relief Association		Your Municipality
Print Name and Title	Signed	Date / /
Address	State Zip Code	Telephone Number ()

A-31369

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

White Copy-Provident Yellow Copy-Workers' Compensation Pink Copy-Department or Company

Underwritten by Provident Life and Accident Insurance Company
 1 Fountain Square, Chattanooga, TN 37402