WORKERS' COMPENSATION TELEPHONE REPORTING WORKSHEET

THINGS TO REMEMBER WHEN COMPLETING THE INFORMATION BELOW:
Call the Telephone Reporting Center to quickly and easily report all Workers' Compensation injuries. We will be asking you the following questions, so please have the information handy. We will produce and submit the necessary state forms.

DO NOT DELAY IN CALLING IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.

ACCOUNT / ACCIDENT INFORMATION

CALLER'S PHONE NUMBER / EXTENSION	CALLER'S TITLE	CALLER'S NAME	REPORTING STATE
( )			

SUBSIDIARY NAME	SUBSIDIARY'S ADDRESS (STREET, CITY, STATE & ZIP)	SUBSIDIARY'S MAILING ADDRESS (STREET, CITY, STATE & ZIP)
		☐ SAME

DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS?
☐ YES ☐ NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED

PARENT COMPANY / INSURED'S NAME
Fauquier County Fire & Rescue Association

LOCATION CODE	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS
	6C28UB-0640N79-7-10	

DATE OF INJURY	TIME OF INJURY

ACCIDENT DESCRIPTION

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER:	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER
		☐ MALE ☐ FEMALE

DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS

EMPLOYEE'S HOME PHONE NUMBER	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)
( )	

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE	INJURED WORKER TYPE	REGULAR OCCUPATION
☐ FULL-TIME ☐ PART-TIME ☐ OTHER____________		

OCCUPATION WHEN INJURED

EMPLOYEE'S WORK SCHEDULE
REGULAR WORK HOURS HOURS/DAY DAYS/WEEK

EMPLOYEE'S WAGE INFORMATION:
$ ________ / HOUR OR $ ________/ ANNUAL OR $ ________ / WEEKLY OVERTIME: $ ________ ADDITIONAL BENEFITS: $ ________.

DATE OF HIRE OR LENGTH OF EMPLOYMENT

SUPERVISOR'S NAME:	SUPERVISOR'S PHONE NUMBER:	BEST HOURS TO CONTACT
	( )	

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK?	IS THE EMPLOYEE BACK AT WORK?
	☐ YES ☐ NO	☐ YES ☐ NO IF YES, DATE RETURNED TO WORK?

RETURN TO WORK STATUS	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH
☐ LIGHT ☐ MODIFIED ☐ REGULAR		☐ YES ☐ NO

CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)

EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED

DO YOU QUESTION THE VALIDITY OF THE CLAIM?
☐ YES ☐ NO

WITNESS INFORMATION/OTHERS INVOLVED

NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER

CONTINUED ON REVERSE SIDE

INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, DESCRIBE)

☐ YES ☐ NO

TREATMENT ("X" ALL THAT APPLY

☐ FIRST AID —	TREATMENT AND DATE OF 1ST TREATMENT
☐ HOSPITAL/ CLINIC —	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1ST TREATMENT, LENGTH OF STAY, AMBULANCE USED? WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ■ NO WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT`? ☐ YES ☐ NO
☐ PHYSICIAN —	

SEE WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS FOR YOUR INDIVIDUAL STATE.

CUSTOMER SPECIFIC INFORMATION

ADDITIONAL COMMENTS & INFORMATION

PROVIDENT
LIFE AND ACCIDENT
INSURANCE COMPANY

272 ALPHA DRIVE
P.O. BOX 11588
PITTSBURGH, PA 15238

(412) 963-1200
800-447-0360
FAX: (412) 963-0415

FIRST NOTICE OF CLAIM

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 ( )
Wages: Hourly: or Weekly:	Date Last Worked / /	
Time of Accident AM ☐ PM ☐ / Date of Accident / /	Place of Accident	
Describe injury or sickness and how it began.		
Name and Address of Treating Physician	Name and Address of Hospital	
Did you lose time from work? ☐ Yes ☐ No ☐ Unknown at this time	Did you file with Workers Compensation? ☐ Yes ☐ No	
I was totally disabled from / / to / /		
I was partially disabled from / / to / /		
Date you have or expect 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 photocopy 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 OR RESCUE SQUAD

☐ Yes ☐ No—Claimant was member of your organization at time of injury ☐ Yes ☐ No—Claimant was engaged in an authorized activity at time of injury	
Name of Fire/Rescue Company/Relief Association or Auxiliary	Your Municipality
Print Name Signed	Title Date
Address State Zip Code	Telephone Number

White Copy—Provident *Yellow Copy—Municipality/Worker's Compensation* *Pink Copy—Fire Department*

A-31369 (Rev. 1-94)

Rev. 10/2010

FAUQUIER COUNTY
WORKERS' COMPENSATION PANEL OF PHYSICIANS

Gregory S. Goulb, MD Chris Ward, MD Shakur Kommu, MD Ash Diwan, MD,	Piedmont Family Practice 493 Blackwell Road Warrenton, Virginia 20186	540-347-4400
Patrick Palumbo, MD	Fauquier Urgent Care 75 West Lee Highway Warrenton, Virginia 20186	540-368-7814
Norris Royston, MD Elizabeth Hoebel, MD Robert Houska, MD	Countryside Family Practice 8452 Renalds Avenue Marshall, Virginia 20115	540-364-1581
Wendy Adeshina, MD Grace Keenan, MD	Nova Urgent Care 528 Waterloo Road Warrenton, Virginia 20186	540-347-7611
William Simpson, MD Kevin McCarthy, MD Demetrius Mauory, MD Joseph David, MD, Jae Lee, MD & Gerhard Kraske, MD	Piedmont Internal Medicine 419 Holiday Court, Suite 100 Warrenton, Virginia 20786	540-347-4200
William J. Bender, MD Harry Gustin, III, MD Jefferson Livermon, MD Patricia Houser, MD, & Lora Gillis, MD	Amherst Family Practice 867 Amherst Street Winchester, Virginia 22601	540-667-8724
Lawrence Moter, MD Marien Vasquez, MD Yasmin Tarter, MD	Pratt Medical Center 12101 Carol Lane Fredericksburg, Virginia 22407	540-368-7814

THE CLOSEST EMERGENCY FACILITY MAY BE USED IN AN EMERGENCY SITUATION. ONCE THE EMERGENCY TREATMENT IS COMPLETED A PANEL PHYSICIAN MUST BE CHOSEN FOR FOLLOW UP CARE

_____ I will select a doctor, if needed, from the approved panel.

_____ I decline to select a doctor from the above panel. I understand that I will have to pay for any medical treatment or doctor's bills, and that I will be denied workers' compensation for any absence based on a disability which is not certified by an approved panel doctor.

______________________________ ____________
Signature of Employee Date

______________________________ ____________
Signature of Employer/Supervisor Date

Specialists Panel available upon request. Please contact Human Resources.