City of Richmond

Administrative Manual

EMPLOYEE REPORT OF INJURY

This report must be sent directly to the Risk Management Department.

ANY EMPLOYEE INJURY MUST BE REPORTED ON THIS FORM

1. Name _____ SS# _____
2. Address _____ Telephone _____
   _____
3. Department _____ Occupation _____
4. Supervisor _____ Date of Birth _____

INJURY INFORMATION

5. Did injury result from your employment? _____
6. Date of Injury _____ Time _____am/pm
7. Date of First Treatment_____
8. Name of Physician _____
9. Is a Personal Physician Request on file with Human Resources Management Department? Yes ☐ No ☐
10. Date left work _____
11. Describe Injury/Injuries _____
    _____
12. Place Accident Occurred _____
13. Activity at Time of Injury _____
    _____
14. Cause of Accident _____
    _____
15. Was Injury Due to Carelessness of Others _____
    _____
16. Name of Witness(s) _____

DISABILITY CAUSED FROM PREVIOUS INJURY

17. Original Injury Causing this Disability _____
    _____
18. Date of Recurrence of Symptoms _____
19. Date of Original Disability _____
20. Date Left Work this Disability _____
21. Name of Physician this Disability _____
22. Give Present Symptoms _____

You should seek immediate medical attention for your injury. Any questions regarding this injury should be directed to your immediate supervisor.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT FALSE RESPONSES MAY RESULT IN DENIAL OF MY BENEFITS AND POSSIBLE DISCIPLINARY ACTION.

ANY PERSON WHO MAKES OR CAUSES TO MAKE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR THE PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY.

Signature: _____ Date: _____