



Amherst County Public Schools

153 Washington Street • PO Box 1257

Amherst, VA 24521

ph: (434) 946 - 9386 • fax: (434) 946 - 9346



TO: Principals & Supervisors

FROM: Teresa Crouch, Finance Manager

SUBJECT: Physicians for Work Related Injuries

DATE: September 15, 2014

Update Physician's List for Work Related Injuries

Amherst Family Practice

Dr. David Pelfrey

Dr. Priya Kohli

124 Ambriar Ct.

Amherst, Virginia 24521

434-946-9565

Physicians Treatment Center

Dr. David Engel

Dr. Matthew Tatom

Dr. Heidi Kind-Wolfe

816 S. Main Street

Amherst, Virginia 24521

434-946-5532

Monelison Family Physicians, Inc.

Dr. David Haga

Dr. Frank Garcia

Dr. Verna Guanzon

4262 South Amherst Highway

Madison Heights, Virginia 24572

434-846-8421

NOTE: Amherst County Public School Employees

Your initial doctor's visit must be to one of the above physicians / practices to be eligible for coverage by workers' compensation insurance.

As of July 1, 2006, the Amherst County Public Schools requires drug testing for all work related injuries.

If you fail to use one of the above medical providers, with the exception of an emergency situation, you shall be liable for the cost of the medical care provided for in accordance with Section 65.1-89 of the Virginia Workers Compensation Law.

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 boxes to the right are for the use of the insurer	VWC file number	Reason for filing
	Insurer code	Insurer location
	Insurer claim number	

Employer		
1. Name of employer	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 (if applicable)	7. Nature of business	
8. Insurer (name and location)	9. Policy number	10. Effective date

Time and Place of Accident		
11. City or county where accident occurred	Did accident occur on <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No
13. State property? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Date of injury	15. Hour of injury
16. Date of incapacity	17. Hour of incapacity	
18. Was employee paid in full for day of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	19. Was employee paid in full for day incapacity began? <input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Date injury or illness reported	21. Person to whom reported	22. Name of other witness
		23. If fatal, give date of death

Employee		
24. Name of employee (Last, First, Middle)	25. Phone number	26. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
27. Address	28. Date of birth	29. Marital status <input type="checkbox"/> Single <input type="checkbox"/> Divorced
	30. Social security number	<input type="checkbox"/> Married <input type="checkbox"/> Widowed
31. Occupation at time of injury or illness	32. Department	33. Number of dependent children
34. How long in current job?	35. How long with current employer?	36. Was employee paid on a piece work or hourly basis? <input type="checkbox"/> Piece work <input type="checkbox"/> Hourly
37. Hours worked per day	38. Days worked per week	39. Value of perquisites per week Food/meals Lodging Tips Other \$ \$ \$ \$
40. Wages per hour \$	41. Earnings per week (inc. overtime) \$	

Nature and Cause of Accident		
42. Machine, tool, or object causing injury or illness	43. Specify part of machine, etc.	Were safeguards or safety equipment <input type="checkbox"/> Yes <input type="checkbox"/> No
44. Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	45. Utilized? <input type="checkbox"/> Yes <input type="checkbox"/> No	
46. Describe fully how injury or illness occurred		
47. Describe nature of injury or illness, including parts of body affected		
48. Physician (name and address)		49. Hospital (name and address)
50. Probable length of disability	51. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	52. At what wage? \$
53. On what date?		54. EMPLOYER: prepared by (name, signature, title)
55. Date		56. Phone number
57. INSURER: processed by		58. Date
		59. Phone number

VICTIM REPORT

The following information is to be completed by the victim as soon as possible following injury and given to building principal/supervisor.

Name: _____

Date of Injury: _____ Time of Injury: _____

Location of Injury (be specific): _____

Describe how injury occurred: _____

List witness(es) of injury: _____

Signature

Date

WITNESS REPORT

To be completed by the witness of an injury as soon as possible following the observance of an injury and given to the building principal/supervisor.

Name: _____

Date Injury Occurred: _____ Time of Injury: _____

Victim's Name: _____

Describe how injury occurred: _____

Were there other witnesses to injury? Can you identify them? _____

Have you talked with the victim? _____

Signature

Date

PREFERRED PROVIDER PANEL CONSENT FORM

(TO BE SIGNED BY THE EMPLOYEE AFTER THE ACCIDENT)

Employee Initial

I have reviewed the panel of physicians provided to me by my employer and selected the medical provider listed below to receive medical treatment for my work related injury.

Employee Initial

I understand that if I fail to use one of the recommended medical providers, except in a medical emergency, I shall be liable for the cost of the medical care provided for in Section 65.1-89 of the Virginia Worker's Compensation Law.

Employee Initial

When calling the provider for an appointment, I will inform them that the treatment is for a work related injury and that the claims administrator is Trigon Administrators, Inc.

Physician: _____

Address: _____

Phone: _____

Employee Social Security Number: _____

Employee Name: _____

Address: _____

Signature: _____ Date: _____
(Employee)

Please forward the original, along with the First Report of Injury to the Business Office. Keep copies for your records.

*Note: Principal/Supervisor: Did you call Teleprompt (1-800-991-5849) to report injury?

Please send all bills to:

SEDGWICK
P O Box 14663
Lexington, Kentucky 40512
1-800-368-8002

PHYSICAL CAPABILITIES FORM

(To be completed by physician and returned to Amherst County Public Schools, Business Office,
P. O. Box 1257, Amherst, Virginia 24521)

**NOTE: This form must be completed by physician and returned to Amherst County Public Schools
after EACH visit)**

Name: _____ Age: _____
School/Dept: _____ Injury Date: _____
Injury/Complaint(s): _____
Employer: _____

FOR PHYSICIAN ONLY

Complaint(s)/Diagnosis: _____

Is Complaint(s)/Diagnosis work related? Yes No
Patient may return to work: Regular Restricted

(1) Work Restrictions: _____

(Include part of body involved)

(2) Length of Restrictions: _____
(Number of days)

(3) Medication prescribed: _____

(4) Does medication prevent patient from working on or around moving equipment, machinery, or driving? Yes No

(5) If answer is "yes", explain: _____

Date of follow up appointment: _____ If referred, please provide physician's Name: _____

Tetanus Booster: Yes No Date of last booster: _____

Further comments: _____

Date: _____

(Name and Address of Physician)