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	12. Employer's premises? ☐ Yes ☐ No	13. State property? ☐ Yes ☐ 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? ☐ Yes ☐ No		19. Was employee paid in full for day incapacity began? ☐ Yes ☐ 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 ☐ Male ☐ Female
27. Address	28. Date of birth	29. Marital status ☐ Single ☐ Divorced ☐ Married ☐ Widowed
	30. Social security number	
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? ☐ Piece work ☐ 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	44. Provided? ☐ Yes ☐ No
46. Describe fully how injury or illness occurred			45. Utilized? ☐ Yes ☐ No
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? ☐ Yes ☐ No	If yes 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

This report is required by the Virginia Workers' Compensation Act

First Report of Accident
VWC Form No. 3 (rev. 10/1/91)

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)

Revised 9/5/97