



## EMPLOYEE'S WORK-RELATED INJURY REPORT (FORM #500)

**Employee:** Complete this report and return to your supervisor or HR Liaison. **Supervisor:** Review the incident with the employee and complete the *Employer's Accident Report* (FORM #600). When completed, both forms shall be forwarded within **48 hours of the accident** to CorVel at [GM-RIVA-EC\\_Claims@Corvel.com](mailto:GM-RIVA-EC_Claims@Corvel.com), with a copy of the form sent to the Department of Human Resources, Risk Management Division, at [risk@loudoun.gov](mailto:risk@loudoun.gov) and your department's HR Liaison, pursuant to Administrative Policies and Procedures HR-44. **Fire/Rescue and LCSO:** Please follow your department's internal procedures before submission to CorVel and DHR/Risk.

INJURED EMPLOYEE OR VOLUNTEER				
NAME/EMPLOYEE ID NO.:		ADDRESS:		PHONE NUMBER:
LENGTH OF EMPLOYMENT:	AGE:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	JOB TITLE (OR INDICATE VOLUNTEER):	

DEPARTMENT INFORMATION	
DEPARTMENT:	DATE YOU NOTIFIED SUPERVISOR:
NAME OF SUPERVISOR NOTIFIED:	HAVE YOU RETURNED TO WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No Date/Time returned:

THE ACCIDENT				
DATE OF ACCIDENT:	TIME:	LOCATION:	DATE REPORTED:	LAST DAY WORKED:
<b>TYPE OF INJURY</b>		<input type="checkbox"/> Bruising	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Strain/sprain	<input type="checkbox"/> Scratch/abrasion	<input type="checkbox"/> Internal	INJURED PART OF BODY: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> N/A	
<input type="checkbox"/> Fracture	<input type="checkbox"/> Amputation	<input type="checkbox"/> Foreign body		
<input type="checkbox"/> Laceration/cut	<input type="checkbox"/> Burn scald	<input type="checkbox"/> Chemical reaction		

<b>PRIOR TO THE ACCIDENT</b> – What were you doing just before the incident occurred? Describe the activity, as well as the tools, equipment or materials you were using, including PPE worn. Be specific. (Example: "Arresting subject.")

<b>DESCRIPTION</b> – How did the injury or illness occur? (Example: "While arresting subject, fell to the ground and landed on arm.")

<b>PREVENTION</b> - What can be done to prevent future occurrences?

MEDICAL TREATMENT	
Did you receive medical treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO	Name of Person/Doctor/Hospital (if applicable):

I certify that the information in this Work-Related Injury Report is true and accurate to the best of my knowledge. I understand that CorVel will rely upon this form in evaluating my claim. I further understand that this document may be presented or used in support of or against a claim for payment under the County's policy of workers' compensation insurance. I understand falsification of any information on this injury report and/or the assertion of a false workers' compensation claim are violations of Virginia's Criminal laws and may result in a fine, imprisonment and/or termination of my employment.

Employee/Volunteer \_\_\_\_\_ Date \_\_\_\_\_  
Signature

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_