COUNTY OF HENRICO
EMPLOYEE'S REPORT OF INJURY

PART I. EMPLOYEE INFORMATION

DEPARTMENT OR SCHOOL	DEPARTMENT OR SCHOOL SECTION	NAME OF SUPERVISOR

Name of Employee:
____
Last First Middle Initial

Employee's Address:
____
Street City State Zip Code

Telephone Numbers: (Day Time) ________________________ (Home) ________________________

Date of Injury:

Time of Injury: (Circle one) ___ a.m. p.m. Date and Time Injury Reported: ___________________
Name of Person to Whom Injury was Reported: ____

PART II. PART OF BODY INJURED

(Mark an "X" next to each body part injured. Circle right R or left L as appropriate.

( ) Abdomen L R	( ) Chest L R	( ) Finger L R	( ) Hip L R	( ) Rib L R	( ) Thumb L R
( ) Ankle L R	( ) Ear L R	( ) Foot L R	( ) Knee L R	( ) Shoulder L R	( ) Toe L R
( ) Arm L R	( ) Elbow L R	( ) Groin L R	( ) Mouth	( ) Stomach L R	( ) Wrist L R
( ) Back L R	( ) Eye L R	( ) Hand L R	( ) Neck L R	( ) Tailbone	
( ) Calf L R	( ) Face L R	( ) Head L R	( ) Nose	( ) Thigh L R	

PART III. NATURE OF INJURY OR ILLNESS

( ) Abrasion	( ) Bite/Sting	( ) Burn	( ) Heart attack	( ) Puncture	( ) Dislocation
( ) Allergic Reaction	( ) Blister	( ) Fall/Slip	( ) Heat Stroke	( ) Sprain/Strain	( ) Concussion
( ) Amputation	( ) Bruise	( ) Fracture	( ) Laceration	( ) Swelling	( ) Other

Describe in detail how you were injured:

PART IV. ACCIDENT LOCATION

(Describe where the injury occurred.)

Henrico County
Richmond, Virginia 23273-7032

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PART V. MEDICAL HISTORY

Did you aggravate a previous wound or condition? Yes _____ No _____ If yes, list injury/illness:

Have you had any previous workers' compensation claims? Yes _____ No _____

PART VI. WITNESSES (Use additional pages if necessary)(Do not include students):

NAME:____
Last First Middle Initial

HOME ADDRESS:____
Street City State Zip Code

TELEPHONE NUMBERS: (Home) ________________________ (Work)________________________

PART VII. GROUP HEALTH PHYSICIANS (List all of your group health physicians)

PART VIII. SIGNATURE

Printed Name of Employee ____________________________ Last First Middle Initial	**Signature of Employee.** The above information is true to the best of my knowledge. ____________________________	
Department:	Telephone Number:	Date:
Printed Name of Supervisor ____________________________ Last First Middle Initial Supervisor Phone ____________________	**Signature of Supervisor.** I have reviewed for completeness and not concurrence. ____________________ Date: __________	