LOUDOUN COUNTY VIRGINIA

CALL 833-746-8307 TO REPORT CLAIM

CorVel Claim No. (if known):1449-WC-_____

EMPLOYER'S ACCIDENT REPORT (FORM #600)

This form shall be completed by the supervisor, HR Liaison, or safety officer (as applicable). When completed, this form shall be forwarded within 48 hours of the accident to CorVel at 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 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.

DEPARTMENT INFORMATION

DEPARTMENT:	NAME OF SUPERVISOR/HR LIAISON/SAFETY OFFICER:

DETAILS OF ACCIDENT

DATE OF ACCIDENT:	TIME:	LOCATION:	DATE REPORTED:

INJURED EMPLOYEE

NAME:	ADDRESS:	PHONE NUMBER:

LENGTH OF EMPLOYMENT:	AGE:	SEX: ☐ Male ☐ Female	JOB TITLE:

TYPE OF INJURY

☐ Strain/sprain	☐ Bruising	☐ Dislocation	☐ Other (specify):
☐ Fracture	☐ Scratch/abrasion	☐ Internal	INJURED PART OF BODY:
☐ Laceration/cut	☐ Amputation	☐ Foreign body	REMARKS:
	☐ Burn scald	☐ Chemical reaction	

DAMAGED PROPERTY (IF APPLICABLE)

PROPERTY/ MATERIAL DAMAGED:	NATURE OF DAMAGE:
	OBJECT/SUBSTANCE INFLICTING DAMAGE:

THE ACCIDENT

DESCRIPTION - Description of what happened.

ANALYSIS - In your opinion, what was the direct cause of the accident?

PREVENTION - What action has or will be taken to prevent a recurrence?

ADDITIONAL INFORMATION – Is there any additional information you would like to provide?

MEDICAL TREATMENT

Did employee seek medical attention? ☐ **YES** ☐ **NO**	Type of treatment given (if known):
Name of Person/Doctor/Hospital:	

_____ Supervisor's Signature

_____ Title

_____ Date