



The following information is designed to assist with timely and accurate reporting, as well as for education on state forms and responsibilities within the claim process.

Included in this packet is the following:

- How to file a work related injury or illness.
- State forms as well as an explanation for completion and how to process
 - Employer's Accident Report – VWC Form No. 3 (rev. 03/22/02)
 - Claim Form & Request for Hearing – VWC Form #5 (rev. 10/08)
 - Notice to Employee – Form VWC-1B (rev. 3/16/06)
 - Workers' Compensation Notice – Form VWC1 – English/Spanish
- The responsibilities of each party involved in the claim. The information contained will assist you in understanding what each party's responsibilities include from the injured employee, client employer, PEO and insurance carrier.
- Coventry/First Script temporary prescription services ID information. This document should be provided to your injured employee at the time they report an injury and are seeking medical attention. The information contained will give pharmacists the information necessary to file the claim form with SUA and should prevent the injured employee from having to pay for the prescriptions related to the work injury. Once the claim is filed with SUA a prescription drug card will be issued to the injured worker for additional prescribed medication.
- Resources and contact information. Included in this information you will find useful internet links for state forms, Coventry Provider Network Information and key contact information for SUA, including names, department and telephone and fax numbers for staff members assigned to your account.
- Posting Notice. The law requires every employer to post and maintain in a conspicuous place or places in and about the worksite, a notice stating that the employer has secured workers' compensation insurance coverage.
- Professional Employer Organizations (PEOs): PEOs doing business in Virginia must register with the Commission pursuant to Virginia Code § 65.2-803.1.
- Employers must give employees a thirty-day notice if their workers' compensation insurance is cancelled or not renewed.

Thank you for choosing SUA Insurance Company

VA01 08/08



HOW TO FILE A WORK INJURY OR OCCUPATIONAL DISEASE CLAIM

Workers' compensation claims can be reported in several different ways, you can:

- Complete and submit the Employer's Accident Report, VWC Form No. 3 (rev. 03/22/02) via the online reporting system available at www.suainsurance.com. Email the completed form to claimsintake@suainsurance.com. **This is the preferred method of reporting an injury.**
- Complete the Employer's Accident Report, VWC Form No. 3 (rev. 03/22/02) and fax to SUA at 877-782-3292.
- Complete and submit the Employer's Accident Report, VWC Form No. 3 (rev. 03/22/02) to:

SUA Insurance Company
Attn: Claims Dept.
222 South Riverside Plaza, Suite 1600
Chicago, IL 60606-6001

- Call the SUA Claims office at 877-782-3291. **Please refer to the Telephone Reporting Guide for assistance.**
- By contacting your broker directly and providing the appropriate first report information.
- For injuries occurring after normal business hours, please call 877-782-2112. The after hours telephone number for reporting claims provides the opportunity to report a claim 24 hours a day 7 days a week. Loss details will be gathered to determine if an emergency exists and if an immediate field contact is indicated.
- An explanation of how to complete each form is included in this packet. Also included are commonly used forms and notices and an explanation of each form's function.

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TELEPHONE REPORTING GUIDE

Employer Information

Employer Name _____
Address _____
Federal Employer Identification Number (FEIN) _____
Payroll Classification Code _____

Employee Information

Name _____
Address _____
Social Security Number _____
Nationality _____
Marital Status _____
Number of Children under 18 years _____
Date of Birth _____
Occupation when injured _____
Hours worked per day _____
Average weekly wage _____

Time and Place of Injury

Location of work site where injury occurred _____
Date of Injury _____
Date Disability Began _____
When did you or the Supervisor first know about the injury _____
Name of Supervisor _____

Cause of Injury

Machine or Equipment that Caused the injury? _____
Was safety appliance provided and in use? _____
Was injury due to failure to use a safety device? _____
Describe how the injury occurred? _____

Nature of Injury

Body Part(s) injured _____
Has the employee died _____
Probable length of disability _____
Date of return to work _____
Doctor's name, address and phone number _____

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STATE FORMS VIRGINIA

- ***Virginia Employer's Accident Report: VWC Form No. 3 (rev. 03/22/02)*** – This form must be completed by the employer or its representative and filed with the insurer who provided insurance coverage on the date of the occurrence within 10 days after the notice of a work-related injury, occupational illness/disease or if the occurrence resulted in death of the worker. Form must be completed with as much available information as possible.
- ***Virginia Claim Form & Request for Hearing: VWC Form #5 (rev. 10/08)*** – *Even if the injured employee has been paid by his/her employer or claim administration for time missed from work because of an injury or for medical treatment for the injury, the employee must file a claim with the Virginia Workers' Compensation Commission to protect his/her right to benefits under Virginia Law. File this Claim Form, with Part A completed, with the Virginia Workers' Compensation Commission as soon as possible. If the employee is requesting a hearing, the employee must file medical reports supporting her/his request with the Virginia Workers' Compensation Commission and complete Part B of this form and submit the medical reports either attached to the form, or as soon as possible.*
- ***Virginia Notice to Employee: Form VWC-1B***
- ***Virginia Workers' Compensation Notice - Form VWC1 – English/Spanish***

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Employer's Accident Report
 (formerly: 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	Reason for filing	VWC file number
	Insurer code or PEO Ref. No.	Insurer location
	Insurer claim number	

Employer				
1. Name of employer (trading as or doing business as, if applicable)		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/Policy Named Insured (if applicable) or PEO name		7. Nature of business (NAICS code, if applicable)		
8. Name and Address of Insurer or self-insurer for this claim		9. Policy number	10. Effective date	
Time and Place of Accident				
11. City or county where accident occurred	12. Date of injury	13. Hour of injury <input type="text"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 13a Time began work <input type="text"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	14. Date of incapacity	15. Hour of incapacity
16. Was employee paid in full for day of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. Was employee paid in full for day incapacity began? <input type="checkbox"/> Yes <input type="checkbox"/> No		
18. Date injury or illness reported	19. Person to whom reported	20. Name of other witness		21. If fatal, give date of death
Employee				
22. Name of employee (Last, First, Middle)		23. Phone number	24. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
25. Address		26. Date of birth	27. Marital status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
29. Occupation at time of injury or illness (SOC code, if applicable)		30. Is worker covered by PEO policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	31. Number of dependent children <input type="text"/>	
32. How long in current job?	33. Date of Hire	34. Was employee paid on a piece work or hourly basis? <input type="checkbox"/> Piece work <input type="checkbox"/> Hourly		
35. Hours worked per day <input type="text"/>	36. Days worked per week <input type="text"/>	37. Value of perquisites per week Food/meals Lodging Tips Other \$ \$ \$ \$		
38. Wages per hour \$	39. Earnings per week (inc. overtime) \$			
Nature and Cause of Accident				
40. Machine, tool, or object causing injury or illness		41. Specify part of machine, etc.		
42. Describe fully how injury or illness occurred				
43. Describe nature of injury or illness, including parts of body affected			43a. Overnight inpatient hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			43b. Treated in Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No	
44. Physician (name and address)		45. Hospital or Clinic (name and address)		
46. Probable length of disability	47. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes	48. At what wage?	49. On what date?
50. EMPLOYER: prepared by (name, signature, title)		51. Date	52. Phone number	
53. INSURER: (name of processor)		54. Date	55. Phone number	
56. THIRD PARTY ADMINISTRATOR (if applicable)		57. Address	58. Phone number	

This report is required by the Virginia Workers' Compensation Act

Employer's Accident Report
VWC Form No. 3 (rev. 03/22/02)

INSTRUCTIONS

Employer's Accident Report (formerly Employer's First Report of Accident) VWC Form No. 3

Employer

1. Fill out this form whenever one of your employees is injured. Provide all the information requested, except the information in the top right corner. **Please type or print all information in black ink.** Your signature is required on line 50 of the form.
2. Send the original beige form to your insurance carrier, claims servicing agency, or third party administrator for processing. If you are self-insured, send it to your organization's designated office for handling workers' compensation claims.
3. If you are an employer subject to OSHA record-keeping requirements, you may retain a copy of this completed form as a supplementary record of occupational injury or illness. Use block #3 (Employer's Case No.) to cross-reference your master log of accidents and illnesses.
4. If you need additional copies of this form, please request them from your insurance carrier, claims servicing agency, or third party administrator.

Insurance carriers, self-insured employers, Professional Employer Organizations (PEO's), and authorized representatives

1. For accidents meeting one of the seven criteria for establishing a Commission Case File,* submit the original beige form and one copy to the Virginia Workers' Compensation Commission at 1000 DMV Drive, Richmond VA 23220. The code for the reason for filing should be written at the top right of the form.
2. When processing these forms prior to transmittal to the Commission, please include the information requested at the top right of the form, verify that the carrier name and policy number given by the employer are accurate, and enter your name and phone number, and the date of processing at the bottom of the form.
3. Insurer code at the top right of the form refers to the five-digit code assigned by NCCI. If you are self-insured, it refers to a similar five-digit number assigned by the Virginia Workers' Compensation Commission. A PEO must use the VWCC reference number.
4. Additional copies of this form are available without cost by writing to the Commission. Please note that color coding of the forms greatly increases the Commission's efficiency in processing claims, and that any alternative versions of the form you develop yourself require prior approval by the Commission. Write to "Forms" at the listed Virginia Workers' Compensation Commission address.
5. On Lines 8 and 9, the employer or carrier is to give the name of the responsible carrier as set forth on the policy (line 8) and that carrier's policy number (line 9).
6. This form can be filed electronically. If you would like more information, please go to the Virginia Workers' Compensation Commission's Web site (www.vwc.state.va.us) or call us at (804) 367-2084.

*The criteria are (1) lost time exceeds seven days, (2) medical expenses exceed \$1,000, (3) compensability is denied, (4) issues are disputed, (5) accident resulted in death, (6) permanent disability or disfigurement may be involved, and (7) a specific request is made by the Virginia Workers' Compensation Commission.

Claim Form & Request for Hearing

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond Virginia 23220
1-877-664-2566



www.vwc.state.va.us

Jurisdiction Claim #: _____

Claim Administrator #: _____

SEE INSTRUCTIONS ON REVERSE SIDE

Injured Worker's Name: _____	Employer's Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____	Employer's Phone: _____

Parts of Your Body Injured: _____

Date of Injury*: _____ Average Earnings per week: \$ _____

***in case of disease, give date doctor told you that disease was caused by work**

PART A (Claim Form) (All injured workers should complete this section for workers' compensation injuries)

I hereby file this claim to protect my rights under the Virginia Workers' Compensation Act for the injury or disease described above. I am not requesting the Commission take any specific action at this time.

Injured Worker's signature Print Name Date

Please sign and return to the Commission. Complete Part B below **only** if you are requesting a hearing.

Part B (Request for Hearing) (You are not required to complete this section—do so only if you are requesting a hearing)

I hereby request a hearing from the Commission. I am seeking the following:

- An Award for medical benefits for my injury (including any treatment already received & paid for) **
- I missed work because of my injury on (dates) _____ **
- I earned less pay because of my injury on (dates) _____ **
- I have a loss of or loss of use of a body part or have disfigurement. **
- I have unpaid medical bills relating to my injury. **
- Other _____

Injured Worker's signature Print Name Date

** Attach medical records or bills.

If there are any questions regarding this form, please contact the Commission toll-free at **1-877-664-2566**.

BARCODE
(Form Identifier & JCN)

**Claim Form &
Request for Hearing
VWC Form #5**

Filing Instructions

1. Even if you have been paid by your employer or claim administrator for time missed from work because of your injury or for medical treatment for your injury, you must file a claim with the Virginia Workers' Compensation Commission to protect your right to benefits under Virginia law. File this Claim Form, with Part A completed, with the Commission as soon as possible.
2. For questions or assistance with completing this form, please contact Customer Assistance using the Commission's toll-free number 877-664-2566.
3. If you are requesting a hearing, you must file medical reports supporting your request with the Commission. If you are requesting a hearing, complete Part B of this form and submit the medical reports either attached to the form, or as soon as possible.
4. If you are not requesting a hearing at this time, you may do so at a later date, but you should still submit this form with Part A completed. To request a hearing at a later date, please contact the Commission at 877-644-2566 or the Commission's website at www.vwc.state.va.us to obtain another copy of this form.
5. You may obtain copies of your medical records directly from your physician. Please contact the Commission at 877-644-2566 for assistance.

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.
2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.
4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee. The voluntary payment of wages or compensation during disability, or of medical expenses, does not affect the running of the time limitation for filing claims. An award based on a voluntary agreement must be entered or a claim filed within two years; one year in death cases.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.
2. Report the injury to the Commission through your carrier or directly to the Commission.
3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV Drive
Richmond, Virginia 23220

1-877-664-2566
vwc.state.va.us

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

NOTICIA SOBRE COMPENSACIÓN LABORAL

Los empleados de ésta empresa estan cubiertos por la Ley de Compensacion Para Los Trabajadores de Virginia (Virginia Workers' Compesation Act). En caso de lesion por accidente o aviso de una enfermedad ocupacional:

EL EMPLEADO DEBE:

1. Dar aviso inmediato, por escrito, al empleador sobre lesiones o enfermedad ocupacional y dar la fecha del accidente o del aviso de la enfermedad ocupacional.
2. Dar aviso inmediato al empleador y a "Virginia Workers' Compensation Commission" de cualquier reclamo por compensación por periodos de incapacidad de más de siete dias despues del accidente. En caso de lesiones fatales, el aviso debe ser dado por uno o mas de los dependientes o herederos del difunto o las personas que los representan.
3. Presentar una solicitud a la Comisión para una audiencia dentro de dos años de la fecha de la lesión por accidente or de la primera comunicación del diagnóstico de enfermedad ocupacional, si no llega a un acuerdo con el empleador en relacion al pago de compensación bajo la Ley.
4. Presentar una solicitud a la Comisión dentro de los dos años de la fecha del accidente, si el tratamiento médico es anticipado por mas de dos años de la fecha del accidente y el empleado no ha recibido una orden de la Comisión.

NOTA: El reporte de accidente del empleador no es la presentacion del reclamo del empleado. El pago voluntario sueldos o compensacion durante la incapacidad o de los gastos medicos, no afecta el transcurso de la limitación del tiempo para presentar reclamos. La Comisión debe de dar una orden cubriendo acuerdos voluntarios y si no, una reclamación debe de ser presentada por el empleado dentro de los dos anos del accidente; un año en caso de fallecimiento.

EL EMPLEADOR DEBE:

1. Al momento del accidente, dar al empleado los nombres de por lo menos tres médicos, de los cuales el empleado puede escoger un médico para su tratamiento.
2. Reportar las lesiones a la Comision a traves de su representate o directamente a la Comisión.
3. Determinar exactamente el salario semanal del empleado, incluyendo sobretiempo, comidas, uniformes, etc.

Preguntas pueden ser contestadas llamando a la Comision. Un folleto explicando la Ley de Compensación Para Los Trabajadores esta disponible sin costo de:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV Drive
Richmond, VA 23220
1-877-664-2566
vwc.state.va.us

Cada empleador dentro de la operacion de la Ley de Compensacion Para Trabajadores en Virginia, DEBE DE EXPONER ESTE AVISO EN UN LUGAR VISIBLE, en la empresa o lugar de negocios.



VIRGINIA FIRST REPORT OF INJURY FORMS PACKET

Virginia Employer's Accident Report: VWC Form No. 3 (rev. 03/22/02)

Virginia Claim Form & Request for Hearing: VWC Form #5 (rev. 10/08)

Virginia Notice to Employee: Form VWC-1B

Virginia Workers' Compensation Notice – Form VWC1 – English/Spanish

Supervisor's Incident Report

Medical Authorization

Wage Statement

Attending Physicians Return to Work Recommendation Record

Job Analysis

Return to Work Log



SUPERVISOR'S INCIDENT REPORT

 Injury(work related)

 Incident

 Illness (work related)

Employee Name (First, MI, Last)			Social Security Number			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			Home Telephone Number			
Employee's Street Address						City			State		Zip Code	
Age		Birth date Mo Day Yr			Job Title			Department				
Employee's Scheduled Work Week When Injured		Start time	End time	Hrs Per Day	Hrs Per Wk	Days Per Wk		Normal Full-Time Schedule for Injured's Work	Start Time	End Time		
Injury date Mo Day Yr		Hour of Day		Last Day Worked Mo Day Yr			Last Day Worked Mo Day Yr			<input type="checkbox"/> No Lost Time <input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return		

Did employee seek medical attention? Yes No

If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will employee complete a drug screening? Yes No

Name of Witnesses Names (Attach statements if available)

1. _____ 2. _____

Injured employee's statement of what happened. (Identify circumstances and equipment involved)

How could this incident been prevented?

What corrective action has been taken?

Part of Body Affected							
<input type="checkbox"/> Eye	<input type="checkbox"/> Hip	<input type="checkbox"/> Head	<input type="checkbox"/> Foot	<input type="checkbox"/> Neck	<input type="checkbox"/> Wrist	<input type="checkbox"/> Back	<input type="checkbox"/> Hand
<input type="checkbox"/> Arm	<input type="checkbox"/> Toes	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Ankle	<input type="checkbox"/> Fingers	<input type="checkbox"/> Elbow	<input type="checkbox"/> Leg	<input type="checkbox"/> Other
Type of Injury							
<input type="checkbox"/> Cut/Abrasion	<input type="checkbox"/> Bruise/Contusion	<input type="checkbox"/> Foreign Object	<input type="checkbox"/> Burn	<input type="checkbox"/> Break	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Exposure	
<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Other						

Comments _____

Supervisor Signature _____

Date _____

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WORKERS' COMPENSATION INJURY MEDICAL AUTHORIZATION

Authorization for Medical Records And Communication Release

By this form or copy thereof, I _____, hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other related medical or medically related facility, insurance company or other organization, institution, or person, that has any records or knowledge of my mental, physical health, history, condition or well being, to supply such information to my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment and as to any other issues including but not limited to diagnosis, prognosis, causal connection of care and treatment to my work injury or duties and ability to work. In conjunction with this, I authorize any treating physician or medical provider to review any additional medical records provided to them.

I understand that by signing this authorization for medical records and communication release that my applicable medical provider will be releasing information subject to the HIPPA restrictions. I specifically waive any rights or protections that I may have under the HIPPA regulation and request that the medical providers release the requested information.

A photo copy of this authorization shall be valid as the original. This release shall remain valid for the length of my claim.

Name (Please Print)

Address (Street, City/Town, Zip Code)

Signature

Date Signed

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WAGE STATEMENT

Employer: _____

Employee: _____

Please provide the **52 weeks** of wages prior to the date of injury of _____

Date employee ceased to work: _____ Date Hired _____

Number of Hours employee is scheduled to work per week: _____ Claim Number _____

Is employee paid by hour, day, week or month _____ At what rate: _____

Does Employee work Overtime Yes No If yes, is Overtime mandatory Yes No

State the date and amount of any pay increases during the past 52 weeks

Date _____ Amount _____ Date _____ Amount _____

Date _____ Amount _____ Date _____ Amount _____

	Dates Incl of each Week Pd			Hrs Wkd	Regular Pay		Overtime Pay			Dates Incl of each Week Pd			Hrs Wkd	Regular Pay		Overtime Pay	
	From	To	Yr							From	To	Yr					
1									27								
2									28								
3									29								
4									30								
5									31								
6									32								
7									33								
8									34								
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17									43								
18									44								
19									45								
20									46								
21									47								
22									48								
23									49								
24									50								
25									51								
26									52								
SUBTOTAL										SUBTOTAL							
										GRAND TOTAL							

This is a correct statement of Employee's earnings as actually taken from Payroll Records

Employer's Signature _____ Title _____ Date _____



ATTENDING PHYSICIANS RETURN TO WORK RECOMMENDATION RECORD

Claim No																											
Patients Name (First)	(Middle Initial)	(Last Name)	Date of Injury/Illness																								
TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK																											
Diagnosis/Condition (Brief Explanation)																											
I saw the and treated this patient on _____ and based on the above description of the patient's current medical problem:																											
1) <input type="checkbox"/> Recommend his/her return to work with no limitations on _____																											
2) <input type="checkbox"/> He/She may return to work on _____ capable of performing the degree of work checked below with the following restrictions:																											
<input type="checkbox"/> Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as docket, ledgers and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met		1. In an 8 hour day patient may: a) Stand/Walk <input type="checkbox"/> None <input type="checkbox"/> 1-4 hours <input type="checkbox"/> 4-6 hours <input type="checkbox"/> 6-8 hours b) Sit <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours c) Drive <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours																									
<input type="checkbox"/> Light Work. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls		2. Patient may use hand(s) for repetitive: <input type="checkbox"/> Single Grasping <input type="checkbox"/> Pushing & Pulling <input type="checkbox"/> Fine Manipulation																									
<input type="checkbox"/> Light Medium Work. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.		3. Patient may use foot/feet for repetitive movement as in operating foot controls <input type="checkbox"/> Yes <input type="checkbox"/> No																									
<input type="checkbox"/> Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.		4. Patient is able to: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Frequently</th> <th style="text-align: center;">Occasionally</th> <th style="text-align: center;">Not at All</th> </tr> </thead> <tbody> <tr> <td>Bend</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Squat</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Climb</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Twist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Reach</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>			Frequently	Occasionally	Not at All	Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Frequently	Occasionally	Not at All																								
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
<input type="checkbox"/> Medium Heavy Work. Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds																											
<input type="checkbox"/> Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds																											
Other Instructions and/or Limitations Including Prescribed Medications:																											
The restrictions are in effect until _____ or until patient is reevaluated on _____																											
3) <input type="checkbox"/> He/She is total incapacitated at this time. Patient will be re-evaluated on _____.																											
Physician's Signature		Date																									



Hand Coordination Activities				
Movement Required	Tool/Machine	Right	Left	Both
Major hand				
Fine manipulation				
Gross manipulation				
Simple grasping				
Power grip				
Hand twisting				
Pushing				
Pulling				
Tools Used by Worker		Weight	No. of Hands Needed to Move	
Objects Worker must Move During Day		Weight	Distance	No. of Workers Needed to Move
Physical Surroundings		Does Employee Walk on Uneven Ground?		
Does Employee Work <input type="checkbox"/> Inside _____% <input type="checkbox"/> Outside _____%		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does Employee Work Around Moving Machinery?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does Employee Drive Automotive Equipment?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, describe:				
Does the Employee Come in Contact with the Following? (indicated type)		Yes	No	Type
Fumes				
Dust				
Mist				
Steam				
Strong Odors				
Poor Ventilation				
Air Conditioning				
Characteristics of Job that cannot be Modified by Employer for this Employee				
Comments and/or Observations				
<input type="checkbox"/> Job Site Evaluation Done		<input type="checkbox"/> Narrative		
Name(s) of Person(s) Interviewed		Title		
Person Completing Analysis		Title	Date	



RETURN TO WORK LOG

Employee Name _____

Supervisor _____

Date	Hours Worked		Tasks Performed	Comment Regarding Employee's Tolerance of Modified Duty Tasks	Employee Initials	Supervisor's Initials
	In	Out				
Sunday / /						
Monday / /						
Tuesday / /						
Wednesday / /						
Thursday / /						
Friday / /						
Saturday / /						

I understand, take responsibility for and acknowledge the _____ has placed me on limitations my physician, Dr. _____ while Participating in this temporary transitional work program.

Employee Signature _____

Date _____



RETURN TO WORK LOG

The Return to Work Log is an efficient method used to monitor and document the specific tasks your employees are performing while on modified duty. It helps to eliminate potential conflicts should questions arise regarding your employees performing work in excess of their restrictions.

- A supply of forms should be centrally located and provided to each department supervisor/manager.
- Attach a copy of the employees' restrictions to the log.
- Have employees write their name on top of the log and have the Supervisor write their name.
- Remind the employees it is their responsibility to follow the restrictions.
- Remind the employees the restrictions apply to occupational and non-occupational activities.
- Employees and Supervisors review all tasks completed each day and indicate any concerns. Initial after each day in confirmation of the review of tasks and consideration of concerns.
- Have the employees sign and date the Log at each week's end.



ROLES & RESPONSIBILITIES

Employee:

If a work place accident should take place, it is your responsibility to take the following actions, injury permitting:

- You must report the accident and injury immediately, in writing if possible, to your supervisor or manager.
- For occupational diseases, you should notify, in writing if possible, your employer as soon as practicable after you become aware of the condition.
- You should immediately file a claim for benefits by completing a VWC Form #5 (rev. 10/08) and submitting the form to the Workers' Compensation Commission. The time limits for filing a claim is within two years from the date of the accident or any right to benefits may be lost. Claims for an occupational disease must be filed within two years from the date the doctor tells you the disease is work related, or five years from the date you were last exposed to the work condition causing the disease, whichever is sooner.
- You must select a doctor from a panel of three provided by your employer or insurance carrier. Do not change doctors without your employer or insurance carrier permission or after a hearing by the Commission.
- Comply with managed care requirements for contracted medical services, including but not limited to doctors, physical therapy locations, and diagnostic testing facilities when available.
- You must seek and accept employment if you are released to light duty, and cooperate with "rehabilitation counselors."

Employer:

Upon notice of a work injury or occupational disease you should take the following steps:

- You must inform the insurance carrier or administrator responsible for the workers' compensation program via the agreed upon method, e.g. online reporting, facsimile, or telephonic reporting.
- You or your representative must complete an Employer's Accident Report, VWC Form No. 3 (rev. 03/22/02) and submit the form to the insurance carrier. The insurance carrier will immediately file the original and one copy of the completed form with the Virginia Workers' Compensation Commission. The additional copy of the Employer's Accident Report will be furnished to the Virginia Department of Labor and Industry.
- To avoid delay of processing the claim it is recommended, at a minimum, the following information be provided to the insurance carrier or administrator:
 - Employee's name
 - Address
 - Telephone number
 - Social security number
 - Brief description of the injury, accident or disease
 - Authorization Release of Medical Information
 - Wage Earnings History
 - Notice of Claim Received
 - Witness statements and supervisor reports, if available.



- You need to provide the employee with a panel of at least three physicians, who are not affiliated with each other, from which to select a treating physician. If you do not provide a panel, the employee may elect to receive treatment from any healthcare provider. In an emergency, the employee may be treated at a hospital, emergency room, or other emergency care facility. You should provide a panel of doctors as soon as possible after the emergency treatment.
- Comply with managed care requirements for contracted medical services, including but not limited to doctors, physical therapy locations, and diagnostic testing facilities when available.

Insurance carrier:

Once SUA receives notice of a work place injury via the agreed reporting method and the claim has been properly verified and set up, SUA will take the following steps:

- Three (3) point contact for all lost time claims, contact to the employer, employee and providers.
- SUA will report injuries on an Employer's Accident Report, VWC Form No. 3 (rev. 03/22/02) form as well as all other required reports to the Virginia Workers' Compensation Commission.
- SUA will ensure a timely determination of compensability by requesting from affected parties any information needed to determine:
 - a. If a temporary or permanent disability exists relative to the employee's ability to do their job.
 - b. If the disability is caused by the employee's work.



SUA INSURANCE COMPANY SUBROGATION PROGRAM

SUA Insurance Company (SUA) recognizes the importance of subrogation and recovery in all lines of business it writes. SUA's dedicated team of professionals works diligently to aggressively identify subrogation, second injury fund, salvage, deductible, and any other type of recovery to mitigate the overall payout of the claim.

SUA claims are handled by experienced claim professionals skilled in all aspects of workers' compensation claims handling and subrogation.

SUA maintains full-time dedicated subrogation specialists on staff overseeing all aspects of the investigation and timely notification to all parties while ensuring our lien is protected and utilized in the most advantageous means to resolve the issue.

SUA's philosophy on recovery is multifaceted and factors in all parties involved with our claims which include the insureds, Partner Agents, claim examiners, Corporate Claim Analysts, and SUA Management.

SUA believes its multifaceted approach gives each party an opportunity to recognize opportunities to help mitigate the overall payout on claims received while also recognizing possible safety hazards that can prevent future accidents from occurring.

For additional information, please contact Ed Eisman at SUA 312-258-6822.

SUA10 08/08



RESOURCES

SUA Insurance – www.suainsurance.com

Coventry Workers' Comp Services – <http://coventrywcs.com>

Virginia Workers' Compensation Commission - <http://www.vwc.state.va.us/> - For General Questions
1-877-664-2566

Virginia Workers' Compensation Benefits Information –
http://www.vwc.state.va.us/employees_guide.htm

Virginia Workers' Compensation Fraud Section - <http://www.vwc.state.va.us/fraud.htm> - To report
alleged Workers' Compensation fraud, call 1-877-623-7283

State of Virginia Employer's Workplace Notice - http://www.vwc.state.va.us/forms_work_comp.htm