Loudoun County
VIRGINIA

CorVel Claim No. (if known): _____

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

Fire/Rescue and LCSO: Please follow your department's internal procedures before submission to CorVel and DHR/Risk. 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, 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.

INJURED EMPLOYEE OR VOLUNTEER			
NAME (Last, First, MI)	ADDRESS:		PHONE NUMBER:
EMPLOYEE ID NO.:	AGE:	SEX: ☐ Male ☐ Female	JOB TITLE (OR INDICATE VOLUNTEER):

DEPARTMENT INFORMATION	
DEPARTMENT:	DATE YOU NOTIFIED SUPERVISOR:
NAME OF SUPERVISOR NOTIFIED:	HAVE YOU RETURNED TO WORK? ☐ Yes ☐ No Date/Time returned:

THE ACCIDENT				
DATE OF ACCIDENT:	TIME:	LOCATION:	DATE REPORTED:	LAST DAY WORKED:

TYPE OF INJURY

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

INJURED PART OF BODY: ☐ Left ☐ Right ☐ N/A

PRIOR TO THE ACCIDENT – 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.")

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

PREVENTION - What can be done to prevent future occurrences?

MEDICAL TREATMENT	
Did you receive medical treatment? ☐ **YES** ☐ **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 Signature _____ Date _____

Supervisor Signature _____ Date _____