CALL 833-746-8307 TO REPORT CLAIM

CorVel Claim No. (if known):________________

Loudoun County
VIRGINIA

EMPLOYER'S ACCIDENT REPORT (FORM #600)

This form shall be completed by the supervisor, HR Liaison, or safety officer (as applicable). **Fire/Rescue and LCSO: Please follow your department's internal procedures before submission to CorVel & DHR/Risk.** When completed, call the claim into CorVel & then 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 Dept of Human Resources, Risk Management Division, at risk@loudoun.gov & your department's HR Liaison, pursuant to Administrative Policies and Procedures HR-44._

DEPARTMENT INFORMATION

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

DETAILS OF ACCIDENT

DATE OF ACCIDENT:	TIME:	STATION LOCATION:	DATE REPORTED:

INJURED EMPLOYEE

NAME:	ADDRESS:	PHONE NUMBER:

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

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:

REMARKS:

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 ____________