CATHOLIC DIOCESE OF ARLINGTON

Office of Risk Management
200 North Glebe Road, Suite 630 • Arlington, VA 22203
Office (703) 841-2503 • Fax (703) 778-9118
riskmanagement@arlingtondiocese.org

INSTRUCTIONS

The form must be completed by **someone other than the injured employee** who is an authorized representative capable of obtaining personnel information about the injured employee and has received a description of the accident or event reported as the cause of injury. All injuries should be reported within 24 hours to obtain a claim number, which the employee will need to seek medical treatment.

NOTE: ***The injured employee is not to seek medical treatment from their personal physician***. A Panel of Physicians is available on the Diocesan Office of Risk Management website and at many work locations.

PLEASE PRINT or use the ON-LINE FILLABLE FORM.

EMAIL COMPLETED FORM TO riskmanagement@arlingtondiocese.org

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EMPLOYER'S FIRST REPORT OF ACCIDENT

SUPERVISOR TO COMPLETE

****PLEASE PRINT****

EMPLOYER

Name of Parish/School: _____ Federal Tax Identification Number: **54-0967542**

Mailing Address: Street: _____ City: _____ State: _____ Zip: _____

Parent Corporation/Policy Named Insured: **DIOCESE OF ARLINGTON** Name of Insurer: Travelers

TIME and PLACE OF ACCIDENT

Location of Injury (address):

Street: _____ City: _____ State: _____ Zip: _____

City or County where accident occurred: _____ Date injury or illness reported to employer: _____

Date of injury: _____ Date of incapacity: _____

Hour of injury: _____ ☐ AM ☐ PM Hour of incapacity: _____ ☐ AM ☐ PM

Time began work: _____ ☐ AM ☐ PM

Did employee lose time from work? ☐ Yes ☐ No

Has employee returned to work? ☐ Yes ☐ No

If yes, on what date? _____

State specific area where injury occurred (e.g.: lobby, classroom, stairwell. office, playground, etc.):

_____

Person to whom reported: _____ Phone: _____

Name of witness: _____ Phone: _____

EMPLOYEE

Name of Employee: Last _____ First _____ Middle _____

Employee Phone Number: _____ SELECT ONE Gender: ☐ Male ☐ Female

Employee Home Address

Street: _____ City: _____ State: _____ Zip: _____

Date of Birth (mm/dd/yyyy): _____ Social Security Number: _____-_____-_____

Employee email: *work* _____ *home* _____

Occupation at time of injury: _____ How long in current job? _____

Date of Hire (mm/dd/yyyy): _____ Employee's Primary Language: _____

Is employee paid on a salary or hourly basis? ☐ Salary ☐ Hourly

Hours worked per day: _____ Wages per hour: $_____

Days worked per week: _____ Earnings per week (*incl overtime*): $_____

NATURE and CAUSE OF ACCIDENT

Machine, tool, or object causing injury or illness: _____ Specify part of machine, etc.: _____

Describe fully how injury occurred: _____

_____

Part(s) of body injured (eg: left arm, right leg): _____ Date of Medical visit (mm/dd/yyyy): _____

Treated in Urgent Care/Emergency room? ☐ Yes ☐ No Overnight inpatient hospitalization: ☐ Yes ☐ No

Hospital or Clinic Name: _____

Hospital or Clinic Address: _____ City: _____ State: _____ Zip: _____

Hospital or Clinic Phone Number: _____

Probable length of disability: _____

Report prepared by: NAME: _____ TITLE: _____ DATE: _____

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Rev. July 2022