CITY OF HAMPTON AND HAMPTON CITY SCHOOLS
Report of Work-Related Injury or Illness Form
EIR FORM 1000

REVISED FEBURAY 2024

THIS FORM MUST BE SUBMITTED TO RISK MANAGEMENT WITHIN 24 HOURS OF THE INJURY
Email: Risk Management
risk_management@hampton.gov
Please make sure to reference your department's directive for additional reporting guidance.

EMPLOYEE INFORMATION

THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE

Name of Employee (Last, Middle, First):	Social Security Number:	Sex: Male ☐ Female ☐

Date of Birth:	Employee Mailing Address:	Employee Contact No.:

Job Title:	Employee No.:	Department and Division:	Supervisor Name and Phone No:

INJURY OR ILLNESS INFORMATION

Date of Injury or Illness:	Time of Injury or Illness: ☐ AM ☐ PM	Time began work: ☐ AM ☐ PM

Location where injury or illness occurred (please give as much detail as possible):

To whom was the injury reported please include name, title, and phone number:	Date Injury or Illness Reported:

INCIDENT TYPE INFORMATION

Please check all that apply below

☐ Bitten/Punctured	☐ Caught In/On/Between	☐ Fall on Stairs	☐ Fall Flat Surface
☐ Struck by	☐ Inhalation	☐ Lifting	☐ Pushing/Pulling
☐ Slip but did not fall	☐ Slipped and Fell	☐ Illness (nausea, etc.)	☐ Temperature
☐ Bending	☐ Driving/Riding	☐ Standing	☐ Walking
☐ Running	☐ Sitting	☐ Squatting	☐ Other:

BODY PARTS AFFECTED

Please check all that apply below

RIGHT SIDE	☐ Abdomen	☐ Groin	☐ Toes	☐ Foot	☐ Ankle	☐ Wrist	☐ Arm	☐ Head
RIGHT SIDE	☐ Lower Back	☐ Upper Back	☐ Neck	☐ Shoulder	☐ Elbow	☐ Eye	☐ Ear	
RIGHT SIDE	☐ Hip	☐ Mouth	☐ Teeth	☐ Chest	☐ Leg	☐ Nose	☐ Hand/fingers	Other:
LEFT SIDE	☐ Abdomen	☐ Groin	☐Toes	☐ Foot	☐ Ankle	☐ Wrist	☐ Arm	☐ Head
LEFT SIDE	☐ Lower Back	☐ Upper Back	☐ Neck	☐ Shoulder	☐ Elbow	☐ Eye	☐ Ear	
LEFT SIDE	☐ Hip	☐ Mouth	☐ Teeth	☐ Chest	☐ Leg	☐ Nose	☐ Hand/fingers	Other:

Please give detailed description of how injury or illness occurred below:

Please choose from the list of providers below. You must choose even if you decide not to seek treatment at this time.

Dr. Roxanne Dietzler ☐	**Dr. John Bossalini Concentra Urgent Care Newport News** ☐	**Dr. Maulin Desai Patient First** ☐	**Dr. Debra Ricciardi, DO Concentra Urgent Care Hampton** ☐	**Dr. Robert Dearnley Velocity Urgent Care** ☐

Was first aid provided? ☐ Yes ☐ No

Are you seeking medical treatment at this time? ☐ YES ☐ NO

Signature of Employee:	Date:
Signature of Supervisor:	Date:

ALL SECTIONS OF THIS FORM MUST BE COMPLETED OR IT WILL BE RETURNED

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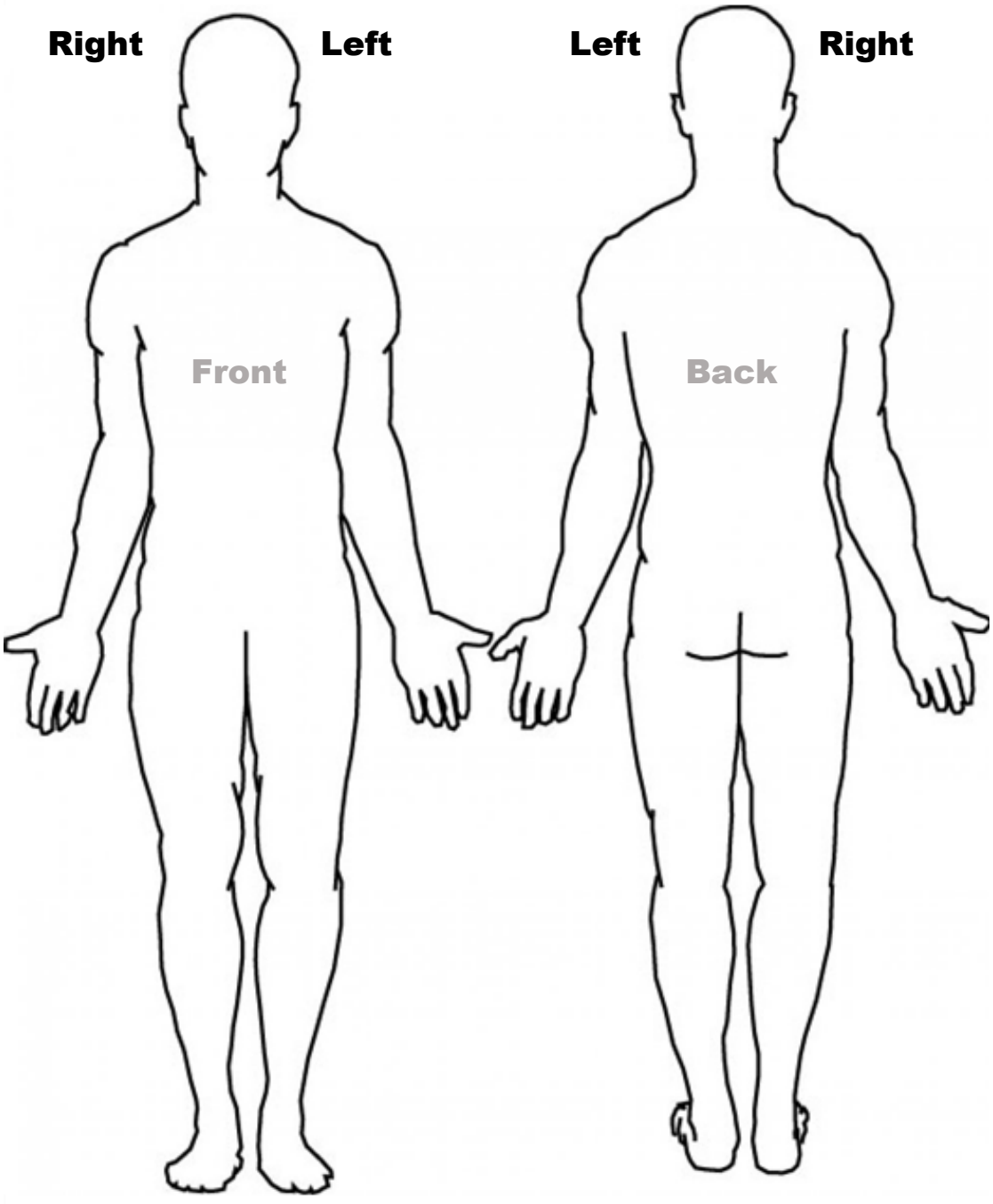
Report of Work-Related Injury or Illness Form
EIR FORM 1000

REVISED FEBRUARY 2024

Name of Employee (Last, Middle, First): **Date of Injury or Illness:**

Please circle and initial the area on the body map that was injured.



ALL SECTIONS OF THIS FORM MUST BE COMPLETED OR IT WILL BE RETURNED

IMPORTANT FACTS ABOUT WORKERS COMPENSATION

You are very important! There are key steps that you must take after the injury. Please see these steps below and be sure to read the City of Hampton's Personnel Policy PAI 6.2 Workers' Compensation.

1. **Even if you choose not to seek medical treatment at this time, you must still pick from the panel of physicians below. Once you have chosen a physician, check the box for the physician on your injury report.**

Why: Workers' Compensation will not cover medical treatment by your primary care physician. If you are seeking medical treatment under your claim, you must seek treatment from a panel physician.

2. **You must submit a work note from the panel physician to your supervisor. The work note will provide restrictions or return you to full duty.**

Why: You must keep your supervisor informed (with a work note) of your physical limitations. After each appointment, you should keep in direct contact with your supervisor and make sure the work note is delivered timely. It is your responsibility to make sure the work note makes it to your supervisor. Failure to provide your updated work notes can jeopardize your benefits. We care too much about you for that to happen. Keep your supervisor informed with your work note after each appointment.

PLEASE CHOOSE FROM ONE OF THE PANEL OF PHYSICIANS

Dr. Debra Ricciardi, DO **Concentra Urgent Care** **593 Aberdeen Rd.** **Hampton, Virginia 23661** **(757) 825-1100** **Monday through Friday: 7:30 AM to 6:30 PM** **Saturday: 9:00 AM to 2:30 PM** **Sunday: Closed**	**Dr. Maulin Desai** **Patient First** **2304 West Mercury Blvd.** **Hampton, Virginia 23666** **(757) 951-1579** **No Appointment Needed/Patient Walk-In** **All week: 8:00am to 10:00 pm** **Open weekends and holidays**
Dr. Robert Dearnley **Velocity Urgent Care** **747 J. Clyde Morris Blvd** **Newport News, Virginia 23601** **(757) 772-6121** **No Appointment Needed/Patient Walk-In** **Monday – Friday: 8:00am-8:00pm** **Saturday & Sunday: 8:00am-4:00pm**	**Dr. Roxanne Dietzler** **732 Thimble Shoals Blvd. Suite 102** **Newport News, Virginia 23606** **(757) 599-3623** **No Appointment Needed/Patient Walk-In** **Monday - Friday: 7:00am- 3:30pm** **Not Open Saturdays or Sundays**
Dr. John Bossalini **Concentra Urgent Care** **803 Diligence Dr.** **Newport News, VA 23606** **(757) 223-7934** **No Appointment Needed/Patient Walk-In** **Monday-Friday 8:00am-5:00pm** **Not Open Saturdays or Sundays**	**Please only use the emergency room for emergencies. Examples of emergencies are: head injuries, loss of consciousness, bone protrusion, and other life-threatening injuries.** **The emergency room can also be used if injured at work after-hours.** **Not all incidents that occur at work are considered to be work-related. You will be notified of a determination upon completion of an investigation.**

CITY OF HAMPTON AND HAMPTON CITY SCHOOLS
PHYSICIAN'S MEDICAL REPORT

TO PHYSICIAN: Please treat _____ for the injury he/she reported receiving while working on (date) _____.

SUPERVISOR: _____ SCHOOL NAME/CITY DEPARTMENT: _____

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Is this event work-related? ☐ Yes ☐ No

Date and Time of Visit: _____ Discharge Time: _____

Diagnosis and Treatment: _____

Is employee taking any medication which could affect behavior or performance at work? ☐ Yes ☐ No

Is employee scheduled for a follow-up visit: ☐ Yes ☐ No If Yes, When? _____

Employee can return to work:

☐ With no restrictions on (date) _____

☐ With restrictions on (date) _____

☐ No work until (date) _____

Please check work restrictions which apply:

☐ No use of affected limb ☐ Limited use of affected limb ☐ Limited walking

☐ Limited bending/stooping/climbing ☐ No work outside ☐ Keep affected part clean and dry

☐ No lifting over _____ lbs. ☐ No operating of equipment ☐ No Driving

☐ Other _____

Additional comments and instructions: _____

_____

Physician's Signature _____

NOTICE TO PHYSICIAN:

We expect the best medical treatment and care you can provide for our employee. We also want him/her to return to work as soon as possible so that he/she can continue to receive full wages and so that we can maintain continued efficiency and minimize our accident costs.

In most cases, we believe that getting the employee back to work is the best rehabilitative treatment we can provide. We recognize that this depends on the physical limitations, if any, and the jobs available. We make every effort to offer temporary work consideration for our employees. Please call Risk Management at 757-726-6617 if there are any questions about our employees not being able to return to work.

Once you have completed this form, please hand it back to the employee so that he/she can return it to the supervisor.

SUPERVISOR: Please send a copy of this form immediately upon receipt to Risk Management by fax or by email.

Email: Risk_Management@hampton.gov
Fax: 757-727-1470

PROVIDE THIS FORM TO THE EMPLOYEE

PMA COMPANIES

EXPRESS SCRIPTS®

First Fill Temporary Prescription Services Card To Be Used Effective January 15, 2013

Attention Injured Worker: On your first visit, please give this notice to any pharmacy listed below to expedite the processing of your approved workers' compensation prescriptions. (Based on the established parameters by your employer.) Questions or need assistance locating a participating pharmacy: Call the Express Scripts Contact Center at 800-945-5951.

Atencion Trabajador Lesionado: Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es). Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 866-945-5951.

Attention Supervisor : Please complete the following information for the injured worker

Express Script ID#: SSN to be presented to the pharmacy at the time the prescription is filled.	**Employee Information**
Date of Injury:	**Name:**
Group#: KVQA	**Address:**
Employee DOB:	**Employer:** CITY OF HAMPTON

Attention Pharmacist: Express Scripts administers this workers' compensation prescription program. Follow the steps below to submit a claim. For assistance, call the Express Scripts Contact Center at 888-786-9640.

Pharmacy Processing Steps

Step1	Enter bin number 003858
Step 2	Enter processor control A4
Step 3	Enter the group number as it appears above
Step 4	Enter the injured worker's 9 digit ID#
Step 5	Enter first name & last name
Step 6	Enter the injured worker's date of injury (enter in PA field in the format ccyymmdd)

Participating Pharmacy Chains

A&P	Acme Pharmacy	Albertson's	Albertson's/Acme
Albertson's/Osco	Albertson's/Sav-On	Amerisource Bergen	Anchor Pharmacies
Arrow	Aurora	Bartell Drugs	Biggs
Bi-Lo	Bi-Mart	BJ's Wholesale	Brooks
Brookshire Brothers	Brookshire Grocery	Bruno	Carrs
Cash Wise	Coburn's	Costco	Cub
CVS	D&W	Dahl's	Dierberg's
Discount Drugmart	Doc's Drugs	Dominicks	Drug Emporium
Drug Fair	Drug Town	Drug World	Eckerd
Econofoods	EPIC Pharmacy Network	FamilyMeds	Farm Fresh
Farmer Jack	Food City	Food Lion	Fred's
Gemmel	Giant	Giant Eagle	Giant Foods
Hannaford	Harris Teeter	H-E-B	Hi-School Pharmacy
Hy-Vee	Jewel/Osco	Kash n Karry	Keltsch
Kerr	Kmart	Knight Drugs	Kroger
LeaderNet (PSAO)	Longs Drug Store	Major Value	Marsh Drugs
Medic Discount	Medicap	Medistat	Meijer
Minyard	NCS HealthCare	Neighborcare	Network Pharmacueticals
Northeast Pharmacy Services	Osco	P&C Food Market	Pamida
Park Nicollet	Pathmark	Pavilions	Price Chopper
Publix	Quality Markets	Raley's	Randalls
Rite Aid	Rosauers	Rx Express	RXD
Safeway	Sam's Club	Sav-On	Save Mart
Schnucks	Scolari's	Sedano	Shaw's
Shop 'N Save	Shopko	ShopRite	Snyder
Stop & Shop	Sun Mart	Super Fresh	Super Rx
Target	Texas Oncology Svc	The Pharm	Thrifty White
Times	Tom Thumb	Tops	Ukrop's
United Drugs	United Supermarkets	Vons	Waldbaums
Walgreens'	Wal-Mart	Wegmans	Weis
Weis			

Note: This form is not valid in the state of Ohio. For all other states, liability of worker's compensation claim is not assumed based on the dispensing of medication(s) to a patient.

PROVIDE THIS FORM TO THE EMPLOYEE