


CITY OF HAMPTON AND HAMPTON CITY SCHOOLS Report of Work-Related Injury or Illness Form EIR FORM 1000  REVISED APRIL 2025		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 instruction 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 <input type="checkbox"/> Female <input type="checkbox"/>
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: <input type="checkbox"/> AM <input type="checkbox"/> PM		Time began work: <input type="checkbox"/> AM <input type="checkbox"/> 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	
<input type="checkbox"/> Bitten/Punctured	<input type="checkbox"/> Caught In/On/Between	<input type="checkbox"/> Fall on Stairs	<input type="checkbox"/> Fall Flat Surface
<input type="checkbox"/> Struck by	<input type="checkbox"/> Inhalation	<input type="checkbox"/> Lifting	<input type="checkbox"/> Pushing/Pulling
<input type="checkbox"/> Slip but did not fall	<input type="checkbox"/> Slipped and Fell	<input type="checkbox"/> Illness (nausea, etc.)	<input type="checkbox"/> Temperature
<input type="checkbox"/> Bending	<input type="checkbox"/> Driving/Riding	<input type="checkbox"/> Standing	<input type="checkbox"/> Walking
<input type="checkbox"/> Running	<input type="checkbox"/> Sitting	<input type="checkbox"/> Squatting	<input type="checkbox"/> Other:
BODY PARTS AFFECTED		Please check all that apply below	
RIGHT SIDE	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Groin	<input type="checkbox"/> Toes <input type="checkbox"/> Foot <input type="checkbox"/> Ankle <input type="checkbox"/> Wrist <input type="checkbox"/> Arm <input type="checkbox"/> Head
RIGHT SIDE	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Eye <input type="checkbox"/> Ear
RIGHT SIDE	<input type="checkbox"/> Hip	<input type="checkbox"/> Mouth	<input type="checkbox"/> Teeth <input type="checkbox"/> Chest <input type="checkbox"/> Leg <input type="checkbox"/> Nose <input type="checkbox"/> Hand/fingers Other:
LEFT SIDE	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Groin	<input type="checkbox"/> Toes <input type="checkbox"/> Foot <input type="checkbox"/> Ankle <input type="checkbox"/> Wrist <input type="checkbox"/> Arm <input type="checkbox"/> Head
LEFT SIDE	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Eye <input type="checkbox"/> Ear
LEFT SIDE	<input type="checkbox"/> Hip	<input type="checkbox"/> Mouth	<input type="checkbox"/> Teeth <input type="checkbox"/> Chest <input type="checkbox"/> Leg <input type="checkbox"/> Nose <input type="checkbox"/> 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 <input type="checkbox"/>	Dr. Debra Ricciardi, DO Concentra <input type="checkbox"/>	Dr. Maulin Desai Patient First <input type="checkbox"/>	Dr. Timothy Lee Sentara Urgent Care <input type="checkbox"/>
Was first aid provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you seeking medical treatment at this time? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Signature of Employee:			Date:
Signature of Supervisor:			Date:

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

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

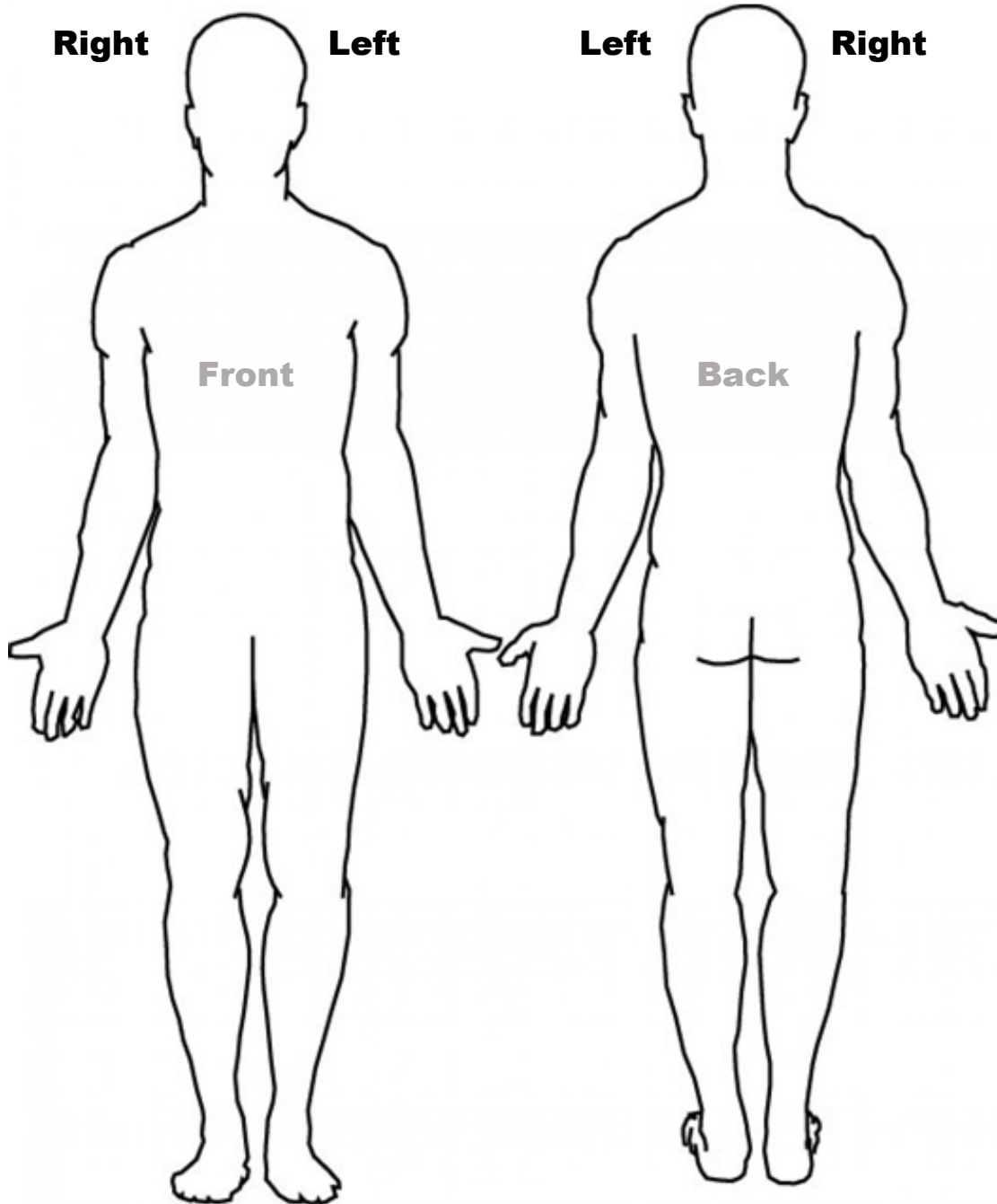


REVISED April 2025

Name of Employee (Last, Middle, First):

Date of Injury or Illness:

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



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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. Timothy Lee Sentara 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
<p>Please use the emergency room for emergencies. Examples of emergencies are: head injuries, loss of consciousness, bone protrusion, and other life-threatening injuries. <u>The emergency room can also be used if injured at work after hours.</u></p> <p>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.</p>	

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 commercial 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



WORKPLACE INJURY PRESCRIPTION INFORMATION

Employer:

Please fill out the employee information below and provide the employee with this document to take to any pharmacy for their workplace injury prescriptions.

Employee:

PMA Companies has partnered with **Cadence Rx** to make filling workers' compensation prescriptions easy. Medications may be subject to formulary and pre-authorization requirements. Please take this letter and your prescription(s) to a pharmacy near you.

Cadence Rx has a network of over 72,000 pharmacies nationwide. To locate a network pharmacy near you, please use the pharmacy locator at <https://cadencerx.com/find-a-pharmacy/> or call Cadence Rx toll-free at 1-888-813-0023.



This document serves as a temporary prescription card. A permanent prescription card specific to your work-related injury or illness will be forwarded directly to you if your claim is deemed compensable for pharmacy benefits.

IF YOU HAVE QUESTIONS OR NEED ASSISTANCE AT THE PHARMACY, PLEASE CALL 888-813-0023

Pharmacist:

Please obtain the below information from the injured employee to process prescriptions for the workplace injury only. Please do not send the patient home or have the patient pay for medication(s) before calling Cadence Rx for assistance.

Note: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

Prescription Drug ID Card		Pharmacy Information
 		<p>This form allows you to fill your initial prescriptions with a maximum cost of \$500 per medication and no more than a 14-day supply per prescription. Pharmacy, if you need assistance processing this claim, please call 1-888-813-0023.</p> <p>The pharmacy benefit card is only to be used for medications prescribed for your work-related injury. By using this card, you acknowledge and accept financial responsibility for any prescriptions billed under this card that are later found to be unrelated to your injury.</p> <ul style="list-style-type: none">Member ID format: The ID must start with FF followed by the last 4 digits of the social security number plus 8- digit DOI (MMDDYYYY). Example: FF999901012018
Employee Name:		
Member ID Number*	*Refer to Member ID Format	
Date of Injury:		
Group Number:	PMACRX	
PCN Number:	CRX	
BIN Number:	021460	
Card Created On: ____/____/____		

Participating Pharmacies/Farmacias Participantes:

Below are some of the major pharmacy chains Cadence Rx partners with/

A continuación se presentan algunas de las principales

cadena de farmacias con las que se asocia Cadence Rx:

Acme Pharmacy	Hannaford	Rite Aid
Albertson's	Harris Teeter	Safeway
Aurora Pharmacy	HEB Grocery	Sam's Club
Bartell Drugs	HY-VEE Pharmacy	Sav Mor Drug Stores
Big Y	Ingles Markets	Save Mart
Bi-Lo	King Sooper's Pharmacy	Shaw's
Bi-Mart	Kinney Drugs	Shoptite
Brooks	Kroger Pharmacy	Smith's Food and Drug Center
Brookshire Brothers	Kmart Pharmacy	Snyder
Brookshire Grocery	Leader Drug Stores	Stop and Shop Pharmacy
Carrs	Longs Drug Store	SuperValu Pharmacy
Costco	Marsh Drugs	Target Pharmacy
CVS	Medicap	Thrifty Drugs
Dillons	Medicine Shoppe	Tom Thumb
Discount Drug Mart	Meijer Pharmacy	Tops
Eckerd Drug	New Albertson's	United Pharmacy
EPIC Pharmacy	Osco	Vons
Food City	Price Chopper	Walgreens
Food Lion	Publix	Walmart
Fred Meyer	Raley's Drug Center	Wegmans
Fry's Food and Drug	Ralphs	Weis
Giant Eagle	Randalls	Winn Dixie