Old Dominion University

:RUNHUV· &RPSHQVDWLRQ $FFI

EMPLOYEE SECTION ±Complete, sign and give to supervisor immediately. Failure to report injury may delay benefits.

Name: _____ DOB: _____ ☐ M ☐ F ☐S ☐W ☐M ☐D
(Last, First, Middle) (Gender) (Marital Status)

UIN: _____ Hire Date: _____ Home Address: _____
(Street, City, Zip Code)

Home Phone: ( ) _____ Department: _____

Work Phone: ( ) _____ ☐Faculty/Staff ☐Hourly ☐Other Time you began work on date of injury: _____
(Employee Type)

Job Title:

: _____

_____

_____

_____

_____

_____

Injuries Sustained: _____
(part of body-left/right)

Name of witness(es): _____

Is medical treatment needed? ☐Yes ☐No
(You must select a physician from the attached panel physician form)

$UH \RX HQUROOHG LQ WKH VW ☐Yes ☐No

Are you enrolled in the Virginia Sickness & Disability Program? ☐Yes ☐No

I certify that the information provided above is true and complete. , DOVR FHUWLI\ WKDW , KDYH UHDG ³,PSRUWDQW ,Q

Signature: _____ Date: _____

SUPERVISOR SECTION ±Complete, sign, and return to Human Resources immediately. Failure to return this form in a timely matter may delay benefits.

Old Dominion University

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7KH 9LUJLQLD :RUNHUV· &RPSHQVDWLRQ Law requires you to choose your doctor from a Panel of at least three physicians. You must select a physician from this Panel to treat your work-related injury. Appointments are not necessary. **If you do not use one of these physicians for your work-related injury, you may be responsible for the cost of medical care.**

Please select a physician from this Panel, complete and sign this form and return it to Human 5HVRXUFHV DORQJ ZLWK WKH FRPSHWHG :RUNHUV· &RPSHQVDWLRQ

Dr. Anthony Russo
9HORFLW\ 8UJHQW &DUH
1326 E. Little Creek Road
Norfolk, VA 23518
757- -

Dr. Maulin Desai
Patient First
3432 Holland Road
Virginia Beach, VA 23452
757-468-1855

Dr. 0LFKDHO %DGGHU
, 2 0HGLFDO &HQWHU
7 7KLPEOH 6KRDOV %OYG
Newport News, VA 2360
757- -

By signing this form, I release all medical information to Managed Care Innovations WKH VWDWH ZRUNHUV· FRPSHQVDWLRQ FAO. Information will be considered confidential and XVHG RQO\ LQ WKH PDWWHU RI WKH ZRUNHUV· FRPSHQVDWLRQ claim.

I have been presented with a panel of at least three physicians and have selected Dr. _____ to provide me with medical care for my work-related injury.

Signed: _____ Date: _____
NAME

Printed: _____ Date of Injury: _____
NAME

Old Dominion University

,PSRUWDQW ,QIRUPDWLRQ DEF
Compensation

Medical expenses for work related injuries are payable, provided a claim has been filed within the required time frame and the insurance carrier accepts your claim and determines the accident/injury falls within the parameters of ´DULVLQJ out of and in the course of employmen W µ If your panel physician certifies that you are unable to work at all, and the claim is determined to be