Instructions for Completing the Employer’s Accident Report (EAR)

The following is a line-by-line description of the information needed to properly complete the EAR. It is imperative that each question is answered or marked N/A if no answer is applicable.

The boxes in the upper right hand corner of EAR are for the insurer and are completed by Managed Care Innovations (MCI).

The remaining sections of the EAR are numerical and are completed as follows:

1. Radford University
2. 546 00 1789
3. Leave blank, completed by the Department of Human Resources.
4. Radford University Department of Human Resources
   314B Tyler Avenue
   P. O. Box 6889
   Radford, VA 24142
5. N/A
6. Commonwealth of Virginia
7. State Government
8. Managed Care Innovations
   P. O. Box 1140
   P. O. Box 1120
   Richmond, VA 23208-1121
9. Self-Insured
10. July 1, 1992
11. Identify the city or county where accident occurred.
12. List actual date of injury as reported by employee.
13. Enter the hour the injury occurred.
13a. Enter the time the employee began work on the date of injury.

14. Enter the date the employee became disabled (unable to work) according to medical information, i.e., medical documentation excusing the employee from work due to the reported injury/illness. If the employee is not excused from work by medical authority, enter N/A.

15. Enter the hour the employee became disabled (unable to work) from work. Normally the time of the injury/illness. May be determined at a later time by medical authority. If the employee is not excused from work by medical authority, enter N/A.

16. For full-time employees, check “yes.” For wage-employees, check “yes” if the employee returns to work after medical treatment or continues to work immediately after the injury/illness. For wage-employees, check “no” if the employee does not return to work after medical treatment or leaves work for the remainder of the work schedule. Wage-employees are paid for hours worked.

17. For full-time employees, check “yes.” For wage-employees, check “no. If there was no incapacity from work, enter N/A.

18. Enter the date the injury or illness was reported. The date reported is the date the employee first informs someone he/she was injured or became ill. Verbal notice from the employee, other third part, or first-hand knowledge by the supervisor is considered proper notice for this purpose.

19. List the name of the person to whom the injury was reported (include the title of this person).

20. List the full name of any witnesses(s).

21. List the date of death if the injury was fatal.

22. Indicate the full legal name (last, first, middle name) of the injured employee.

23. Identify the employee’s home and work phone number including the area code.

24. Check the appropriate box for employee’s sex.

25. List employee’s home (mailing) address, including zip code.

26. List employee=s date of birth.

27. Check the appropriate box for the employee’s marital status.

28. List the employee’s social security number.
29. List the employee's functional job title, i.e., Housekeeping Lead Worker, Grounds Worker Senior, etc., at the time of the accident.

30. Check “no” block.

31. Number of dependent children if known.

32. List the number of months and years employed in the position at the time of the accident.

33. List date hired by agency (Radford University hire date).

34. Check “hourly” box regardless of status, i.e. wage, classified, A/P, Teaching.

35. List the normal number of hours worked per day.

36. List the normal number of days worked per week.

37. N/A does not apply.

38. Leave blank - completed by the Department of Human Resources.

39. Leave blank - completed by the Department of Human Resources.

40. Identify equipment, tool, or object (including people) that caused the injury/illness.

41. Identify the point of impact on the equipment, i.e., blade, wheel, drawer, etc.

42. Identify what the employee was doing at the time of the accident. Describe any conditions which may have contributed to the accident.

43. Describe the part of the body injured, including left, right, upper, lower, etc., as well as fracture (broken), strain, sprain, etc.

43a. Check “yes” or “no.”

43b. Check “yes” or “no.”

44. List the name and address of the physician selected from the panel of physicians provided by your agency. If physician has not been selected when EAR is prepared, leave blank. Do not delay EAR.

45. List the name and the address of the hospital providing services, if applicable.

46. Provide the best estimate of probable length of disability. If medical information is
available indicating the employee will be out of work, enter the approximate number of days. If employee is not released from duty by medical authority, enter “None” or “N/A.”

47. Check “yes” if you know the employee has returned to work or will return to work after completion of the medical appointment, if any. If the employee is not medically released to return to work, check “no”.

48. If item #47 is “yes”, enter “same”. If item #47 is “no”, enter “N/A”.

49. List the date the employee returned to work. If employee either does not go to the doctor/emergency room for treatment, enter the date returned (may be the same date as date of injury if medical treatment is not needed or if employee returns to work the same day).

50. List printed name and title of person preparing the EAR. Person preparing EAR must sign the EAR. The employee listed in item #22 may not prepare the EAR. The EAR is prepared based on known information as the time the report is prepared.

51. List the date the EAR is prepared.

52. List area code and telephone number for the person completing this form.

53. Leave blank - completed by Managed Care Innovations.

54. Leave blank - completed by Managed Care Innovations

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57. Leave blank – completed by Managed Care Innovations.

58. Leave blank – completed by Managed Care Innovations.