VWC #3-A

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE WORKERS' COMPENSATION ACT.

COMMONWEALTH OF VIRGINIA

VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV DRIVE
RICHMOND, VIRGINIA 23220

VWC Claim No. _____

Case of _____

SUPPLEMENTARY REPORT

If Employer's First Report of Injury did not show that the injured had returned to work, an Employer's Supplemental Report of injury should be completed and filed immediately after return to work of the employee. In the event of the death of the employee, this report should be filed immediately.

1. Name of Employer _____
2. Office address: No. and St. _____ City or Town _____ State _____
3. Insured by: Name of Company _____
4. Name of Injured (in full) _____ (First Name) (Middle Name) (Last Name)
5. Present address: No. and St. _____ City or Town _____ State _____
6. Date of Injury _____ 19____ Day of week _____ Hour of day____ A.M. _____ P.M.
7. Date Disability began _____ 19____ A.M. _____ P.M. _____
8. Has injured returned to work? _____ If so, date and hour _____ A.M. _____ P.M.
9. Is injured person earning same wages as before injury?_____ If not, explain _____
10. If disability has not terminated, state probable date of termination of disability_____
11. Has injured died?_____ If so, date death _____ A.M. _____ P.M.

NOTE: This form is not an agreement and its filing is not sufficient to terminate an outstanding award.

Date of this report _____ Firm name _____

Signed by _____ Official Title _____