

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. _____

SUPPLEMENTARY REPORT

Case of _____

If Employer's Accident Report 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)		Last	First	Middle Name
5	Present address: No. and St.			City or Town	State
6	Date of Injury	Date	Day of Week	Hour of Day	AM or PM
7	Date Disability began			Date	AM or PM
8	Has injured returned to work?			If so, date and hour	AM or PM
9	Is injured person earning same wages as before injury?			Yes or No	If not, explain
10	If disability has not terminated, state probable date of termination of disability				
11	Has injured died?			If so, date of death	AM or PM

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