

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

Claim No _____

Case of _____

SUPPLEMENTARY REPORT FOR FATAL ACCIDENTS
(A first report of accident must also be made in every case.)

1. Name of employer _____, 2. Address _____

3. Date of accident- _____, 4. Date of death _____

5. Name of employee _____, 6. Address _____

7. Dependents:

Table with 4 columns: NAME, DATE OF BIRTH, RELATIONSHIP, PRESENT ADDRESS. Rows labeled a through g.

8. Immediate cause of death _____

9. If employee left no dependents, give name and address of nearest relative _____

10. Did you authorize burial expenses? _____ If so, for what amount? _____

11. Name and address of undertaker _____

Date of this report _____

Corporate or firm name _____

Signed _____

Official Title _____

NOTE.-Every question must be answered. Report must be signed by employer or his duly authorized agent. The Commission will not accept copies, or reports signed on typewriter.