Please return form to Virginia Victims Fund, Post Office Box 26927, Richmond, Virginia, 23261

VIRGINIA VICTIMS FUND
Helping Innocent Victims of Crime
OFFICIALLY CRIMINAL INJURIES COMPENSATION FUND

Employer Report

A Division of the Virginia Workers' Compensation Commission

Web: www.virginiavictimsfund.org · Mail: P.O. Box 26927, Richmond, Virginia 23261 · Phone: 1.800.552.4007 · Fax: 804.823.6905

Name of Employee: _____ **VVF Claim No:**_____

Employed from _____ to _____ ◯ **Full-time** ◯ **Part-time** ◯ **Seasonal**

If terminated, when _____and why _____

Average gross WEEKLY wage, including tips and commissions $ _____

If hourly, employee worked average of _____ hours per week at a rate of $ _____ per hour

The number of days worked per week was _____and employee usually worked on:

☐ **Sunday** ☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday** ☐ **Saturday**

Did employee miss work due to crime? **Yes** ◯ **No** ◯ If yes, when?_____thru _____

Was employee paid for any time missed? **Yes** ◯ **No** ◯ If no, NUMBER OF DAYS NOT PAID _____

Number of Days Paid _____

If yes, HOW? Please specify what dates were paid and indicate the number of hours/days paid:

☐ **Vacation leave**_____ ☐ **Sick Leave** _____

☐ **Other**_____(please make additional comments on your office letterhead)

If insurance benefits are available to the employee through your business (i.e., health, dental, eye care, mental health, life, disability), please provide complete contact information. If more than one carrier, please submit additional information on your office letterhead.

Name _____Policy No. _____

Address _____

Name of Business _____Telephone _____

Type or Print Name_____Title _____

_____ _____

Print Employer's Name Employer's Signature

City/County of_____ Commonwealth/State of _____

Subscribed and sworn before me this _____day of_____, _____

Signature of Notary Public _____

My commission expires the _____ day of_____, _____

Notary Seal Number _____