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

Work Release

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

This form should be returned to:

Virginia Victims Fund
Post Office Box 26927
Richmond, VA 23261

Claim No. _____

Victim: _____

Address: _____

_____

CHECK APPROPRIATE BOX AND FILL IN BLANKS

I certify that, because of injuries sustained on: _____

☐ The above-named victim will be constantly totally disabled from returning to work until _____ .

☐ The victim has already been released to return to work. The first day the victim could work was _____ .

☐ The above victim has not been released to return to work. In my opinion, the expected date of release to return to work will be _____. The scheduled appointment closest to that date is _____, and at that time will be able to determine if this victim is still totally disabled.

Additional Comments

This form must be completed by a medical doctor

_____
Signature of Physician Date

_____
Type or Print Name Legibly

_____
Mailing Address

_____
City, State, Zip Code

_____
Telephone Number