

Termination of Wage Loss Award

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond Virginia 23220
1-877-664-2566



www.vwc.state.va.us

Jurisdiction Claim #: _____

Claim Administrator #: _____

SEE INSTRUCTIONS ON REVERSE SIDE

Injured Worker's Name: _____	Employer's Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: () - _____	Employer's Phone: _____
Date of Injury: _____	Pre-Injury Average Weekly Wage: _____

Payment of Compensation pursuant to the open award is terminated for the reason indicated below. (Choose A or B)

- A. The Injured Worker **returned to work** on _____ (m/d/yyyy) at a wage equal to or greater than the pre-injury average weekly wage.
- B. The Injured Worker **was able to return to pre-injury work** on _____ (m/d/yyyy). (Documentation supporting release must be attached.)

THIS AGREEMENT IS SUBJECT TO VERIFICATION BY THE COMMISSION PURSUANT TO THE VIRGINIA WORKERS' COMPENSATION ACT

Signatures REQUIRED

Signing this form indicates the parties agree that the injured worker returned to work at the pre-injury wage or is able to return to pre-injury work.

_____ Signature of Injured Worker	_____ Print Name	_____ Date (m/d/yyyy)
_____ Signature on behalf of the Employer/Insurer	_____ Print Name	_____ Date (m/d/yyyy)
_____ Print Name and Address of Claim Administrator		_____ Phone Number
_____ Print Name and Address of Injured Worker's Attorney		_____ Phone Number

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VWC Form #46**

Filing Instructions

Claim Administrator or Authorized Representative:

1. This form is to be completed when the Injured Worker returns to work at the pre-injury wage or is able to return to pre-injury work. Submit the completed form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220.
2. Check the appropriate reason for the termination of the Award and provide the return to work date and wage information, if applicable.
3. If the basis for terminating benefits is for reasons other than what is contained on this form, you may need to file an Employer's Application for Hearing (VWC Form No. 5A) to terminate the outstanding Award. This form may not be modified to meet a specific case, or the form will be rejected.

Injured Worker:

Signing this document is NOT a requirement for payment. If you do not agree with the information contained and make modifications, it will be rejected. If you have any additional disability from work in the future, your claim can be reopened with the following limitations:

* For questions or assistance with completing this form, please contact Customer Assistance at the Commission's toll-free number 877-664-2566.