Please return form to Virginia Victims Fund: P.O. Box 26927, Richmond, Virginia, 23261 or Fax: 804-823-6905

Employer Report

A Division of the Virginia Workers' Compensation Commission

Web: virginiavictimsfund.org • Mail: P.O. Box 26927, Richmond, VA 23261 • Phone: 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 (at the time of the crime): $ ____________________

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? ____/____/____ to ____/____/____.

Was the 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 ______________________________

Employer Request

Today's Date

Employer Name and Address:

Claim No.:

Claimant:

To Whom It May Concern:

I have filed a claim with the Virginia Victims Fund (VVF) related to a crime committed against me on (date of crime). As part of the review process required under § 19.2-368.6 (B) of the Code of Virginia, certain employment information must be verified.

To help with this process, I am asking for your assistance in completing the attached Employer Report Form. Even if there was no wage loss, if I was not employed at the time, or if my employment was scheduled to begin after the incident, the form still needs to be filled out so that VVF can move forward with its review.

I appreciate your time and attention to this request, and thank you for your help in providing the information needed to support this process.

Sincerely,

Please return this form to the Virginia Victims Fund: P.O. Box 26927, Richmond, VA 23261 or fax to 804-823-6905.

Attachment