VWC #3-B

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:

	NAME	DATE OF BIRTH	RELATIONSHIP	PRESENT ADDRESS
a.				
b.				
c.				
d.				
e.				
f.				
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 _____, 19___.

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.