Memorandum of Agreement

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond VA 23220
See instructions on the reverse of this form.

The boxes to the right are for the use of the insurer	Reserved	VWC file number
	Insurer code	Insurer location
	Insurer claim number	

Employer

Name of employer		Address
Phone number	Federal Tax Identification Number	

Employee

Name of employee	Phone number
Address	Date of birth
	Social security number

Time and Place of Accident

City or county where injury or illness occurred	Cause of injury or illness
Nature of injury or illness, including parts of body affected	
Date of injury or illness	List first seven days of incapacity

Terms of Agreement

We certify that the facts relating to this accident are correct as presented on this form, and agree that the employee shall receive the compensation indicated below until terminated in accordance with the provisions of the Workers' Compensation Act.

Temporary Total

$_________ shall be paid per week beginning _________, 19 _____, based on a pre-injury average weekly wage of $_________.

Temporary Partial

$_________ shall be paid per week beginning _________, 19_____, based on a current weekly wage of $_________ compared to a pre-injury average weekly wage of $_________.

Permanent Partial

$_________ shall be paid per week for _____ weeks beginning _________, 19_____, based on a _____% loss (or loss of use) of the ________________, and a pre-injury average weekly wage of $_________. This compensation shall be payable ______________.

Signatures

Employer	Date	
Employee, guardian, or committee	Date	
Insurer or authorized representative (include name of company)	Date	Phone number
Name and address of employee's attorney (if represented)	(This space for Commission use) Fee Approved by Date	

This report is required by the Virginia Workers' Compensation Act