Termination of Wage Loss Award

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

SEE INSTRUCTIONS ON REVERSE SIDE

www.workcomp.virginia.gov

Jurisdiction Claim #: _____

Claim Administrator #: _____

Injured Worker's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: ( ) -

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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 of Claim Administrator	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

Termination of Wage Loss Award
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:

1. If the claim is for wage loss benefits, your claim must be reopened within 24 months from the last date for which you were entitled to compensation paid under an Award.

2. If the claim is for permanent disability, your claim must be made within 36 months from the last date for which you were entitled to compensation paid under an Award.

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