

# Award Agreement

(Agreement to Pay Benefits)

Virginia Workers' Compensation Commission  
333 E. Franklin St., Richmond, Virginia 23219  
877-664-2566



workcomp.virginia.gov

Jurisdiction Claim #: \_\_\_\_\_

Claim Administrator #: \_\_\_\_\_

SEE INSTRUCTIONS ON REVERSE SIDE

Injured Worker's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer's Phone: \_\_\_\_\_

**Body Parts/Injuries Accepted:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date of Injury:** \_\_\_\_\_ **Pre-Injury Average Weekly Wage:** \_\_\_\_\_

**Payment of Compensation** Check one:  Initial period  Additional period  Corrected period  
(Check all that apply)

- A. **Temporary Total** at the compensation rate of \$\_\_\_\_\_ per week. This period of disability began on \_\_\_\_\_ (m/d/yyyy).
- B. **Temporary Partial:** Please select option 1 or 2 below and complete.
  - 1 - Will be paid at the compensation rate of \$\_\_\_\_\_ per week. This period of disability began on \_\_\_\_\_ (m/d/yyyy)
  - 2 - Was paid an averaged weekly compensation rate of \$\_\_\_\_\_ per week from \_\_\_\_\_ through \_\_\_\_\_ and will continue to be paid at a compensation rate of \$\_\_\_\_\_ per week beginning on \_\_\_\_\_ (m/d/yyyy)
- C. **Permanent Partial** at the compensation rate of \$\_\_\_\_\_ per week. This period of disability began on \_\_\_\_\_ (m/d/yyyy) for \_\_\_\_\_%  loss of use,  loss, or  disfigurement of the \_\_\_\_\_. **Note: Medical report(s) or amputation chart must be attached.**  
Do the parties agree to have this award paid in a lump sum with the 4% discount deducted?  Yes  No
- D. **Permanent Total** the compensation rate of \$\_\_\_\_\_ per week. This period of disability began on \_\_\_\_\_ (m/d/yyyy) .
- E. **Medical Only.** The parties agree to an award for payment of medical benefits that are reasonable, necessary, authorized and causally related to the compensable injury.

**THIS AGREEMENT IS SUBJECT TO ADJUSTMENT AND APPROVAL BY THE COMMISSION PURSUANT TO THE VIRGINIA WORKERS' COMPENSATION ACT**

## Signatures REQUIRED

**By signing below, we certify that the facts relating to this accident are correct as presented on this form and agree that the Injured Worker shall receive compensation or benefits indicated until suspended in accordance with the provisions of the Virginia Workers' Compensation Act.**

_____ 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

**Award Agreement  
Form #50**

**Filing Instructions**

1. This form is to be completed whenever a claim has been accepted as compensable and the Injured Worker is entitled to an award. This Award Agreement provides the basis for the award of compensation and contains sufficient information to establish the essential elements of a compensable claim. Submit the completed form to the Virginia Workers' Compensation Commission, 333 E. Franklin St., Richmond, Virginia 23219.

2. Definitions of Benefit Types:

**Temporary total (TT) disability** – Injured Worker is totally disabled from work and is entitled to receive compensation for a period of total wage loss based upon 66 2/3% (.66667) of the pre-injury average weekly wage.\*

**Temporary partial (TP) disability** – Injured Worker is partially disabled from work but is entitled to receive compensation for a period of partial wage loss based upon 66 2/3% of the difference between the pre-injury average weekly wage and the post (current) average weekly wage. Forms received without specific dollar amounts or those that reflect the word "various" will be rejected. \*

Calculation of Temporary Partial Rate:	Average weekly wage before injury	\$
	– <u>Current weekly wage</u>	<u>\$</u>
All Amounts are Based on Weekly Figures	= Difference in wages before injury and now	\$
	x <u>.66667</u>	<u>\$</u>
	<b>Temporary Partial Compensation Rate</b>	<b>\$</b>

**Permanent partial (PP) disability** – Injured Worker is entitled to receive compensation based upon the loss of use or the loss of a ratable body part, based upon 66 2/3% (.66667) of the pre-injury average weekly wage for a specified number of weeks, pursuant to Va. Code §65.2-503. Please attach a copy of the medical report or the amputation chart that supports the permanency rating to the agreement form. If Permanent Partial is for disfigurement, the Commission must set the rating based on submitted photographs.\*

**Permanent Total** – Injured Worker is permanently and totally disabled from work and is entitled to receive compensation for the remainder of his/her life based upon 66 2/3% (.66667) of the pre-injury average weekly wage.\*

**Medical Only** – The parties agree that the Injured Worker sustained a compensable injury for which the employer and insurer will accept responsibility only for the medical expenses incurred as a result of a work related injury or occupational disease.

\* Compensation rate is subject to yearly maximum and minimum allowances.

\*\* All wage information and compensation rate(s) reflected on the form(s) should be based on weekly figures.

3. Have questions about the Virginia Workers' Compensation Commission and no lawyer? Call the Ombuds Department at 833-448-1681, or email at [ombuds@workcomp.virginia.gov](mailto:ombuds@workcomp.virginia.gov). We cannot give legal advice, but all conversations will be kept confidential.