



Jurisdiction Claim Number (JCN) _____

SEE SPECIAL INSTRUCTIONS ON THE REVERSE SIDE

Employee Information

| | | | |
|---------------|------------|------------------------|----------------|
| Name _____ | | Date of Accident _____ | |
| Address _____ | City _____ | State _____ | Zip Code _____ |

The Employer is requesting to suspend benefits for the following reason(s) [attach supporting documentation]:

- The employee returned to pre-injury work on _____.
- The employee was released to return to pre-injury work on _____ per Dr. _____'s report dated _____.
- The employee returned to light-duty work on _____ at an average weekly wage of \$ _____.
- The employee's current disability is unrelated to the industrial accident noted in Dr. _____'s report(s) dated _____.
- The employee failed to report to an employer-requested medical examination with Dr. _____ on _____.
- The employee refused selective employment within the employee's physical capacity at _____ on _____.
- The employee failed to cooperate with vocational rehabilitation efforts (documentation must be attached).
- The employee has refused medical treatment offered by Dr. _____ as noted in the medical report dated _____.
- Other _____

- Request:**
- Termination/suspension of the outstanding award
 - Change of an outstanding award for temporary total to temporary partial
 - Credit
 - Other _____

Compensation was paid through _____ at the rate of \$ _____ per week.

I hereby certify under penalty of perjury that the statements in this application are true and correct to the best of my knowledge and that a copy of this application, **INCLUDING INSTRUCTIONS ON THE REVERSE SIDE**, and all attached supporting documents were sent to the employee at the above address, and to the employee's attorney (if known) at _____, and to the Virginia Workers' Compensation Commission on _____ (date).

APPLICANT'S NAME AND TITLE

EMPLOYER/CARRIER

SIGNATURE OF APPLICANT

DATE

Registered WebFile Users: Type in your signature if submitting through your WebFile account.

Notice to the employee: If the Virginia Workers' Compensation Commission approves this application, your compensation benefits will be suspended. Please refer to the additional instructions on the back of this form.

Employer's Application for Hearing

Employer Instructions



Complete the Employer's Application for Hearing on the reverse side of this form. The form must be signed, under penalty of perjury, and sent to the Virginia Workers' Compensation Commission with supporting documentation. You may submit this form with your electronic signature and supporting documentation via your WebFile account at webfile.workcomp.virginia.gov. At the time the application is filed with the Commission, a copy of the application and the supporting documentation must be sent to the employee and to the employee's attorney, if represented.

The employer must send the employee a copy of the "Employee Instructions" as shown below.

Compensation must be paid in accordance with the Virginia Workers' Compensation Commission Rule 1.4 (C). If you are relying on Rule 1.4 (F), please indicate that compensation benefits continue to be paid.

You will be notified in writing if the Virginia Workers' Compensation Commission finds it appropriate to suspend compensation benefits or if a determination is made that compensation benefits should not be suspended pending a hearing.

Employee Instructions



If you wish to contest the suspension of compensation benefits pending a final determination by a deputy commissioner, you must provide the Virginia Workers' Compensation Commission with a written statement explaining why your compensation benefits should be continued. This statement and any supporting documentary evidence must be received at the Commission's office 15 days from the date of this application.

If after examining this application, the attached documentation, and the employee's response, the Virginia Workers' Compensation Commission determines that compensation benefits should not be suspended, you will be notified in writing and your compensation benefits will immediately be resumed.

If the Virginia Workers' Compensation Commission finds it is appropriate to suspend benefits until a final determination can be made by a deputy commissioner, you will be notified either that the case is being referred to the evidentiary docket or that a final decision will be made based on the written record.

Ombuds Department

Have questions about the Virginia Workers' Compensation Commission and no lawyer? Call the Ombuds Department at 833-448-1681. We cannot give legal advice, but all conversations will be kept confidential.