



Virginia Birth-Related Neurological Injury Compensation Program 2025 Participating Hospital Information Form

Instructions: Please complete this Participating Hospital Information Form and return it with the Participating Hospital Agreement and a check to the address listed below.

1. Enter total number of live births as reported in schedule 8.2 of your most recent Annual Historical Filing to Virginia Health Information (acting under contract with the Virginia Department of Health): _____ deliveries.
2. Multiply the number of births by \$55.00 = _____.
3. Amount enclosed: \$ _____ (Maximum is \$200,000).

4. **PLEASE PRINT OR TYPE:**

Contact Name: _____

Facility Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____

E-mail: _____

Federal Identification #: _____

Please return this form, participating agreement and check to:
Virginia Birth-Related Neurological Injury Compensation Program
c/o Truist Bank
P.O. Box 91739
Richmond, VA 23291-1739
Phone 804-330-2471
Fax 804-330-3054