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VERMONT

DEPARTMENT OF LABOR – ATTN: WORKERS' COMPENSATION
PO Box 488
Montpelier, VT 05601-0488

Form 1 (Rev. 2/09)
(Approved for use as OSHA 101 and 301)

State File No. _____

EMPLOYER FIRST REPORT OF INJURY

Complete form and send original to the Commissioner of Labor within 72 hours of accident. Send duplicate to your workers' compensation insurance company, give Employee's copy to employee and retain Employer's copy for your files. Answer every question fully and report promptly to avoid a penalty. Employer's Federal ID Number and Employee Social Security Number MUST be provided.

EMPLOYER

1. Legal Name:
2. Business Name:
3. Mail Address: No. and Street | City | State | Zip
4. Location (if different from Mail Address):
5. Federal ID No.:
6. Nature of Business (list principal products or service of concern):
7. Do you regularly employ 10 or more employees? ☐ Yes ☐ No
8. Telephone No.:

EMPLOYEE

9. Name: First Name | Middle Initial | Last Name
10. Social Security No.:
11. Date of Birth:
12. Home Address: No. and Street
13. Telephone No.:
14. Job Title:
15. Age:
City | State | Zip
16. Dept. assigned to:
17. Sex: ☐ M ☐ F
18. Wages $ Per | Hours Per Day | Days Per Week
19. If board, lodging, etc. were furnished in addition to wages, state estimated value: $
20. Was employee hired in VT? ☐ Yes ☐ No
21. Date of Hire

ACCIDENT

22. Date of Accident: | Accident Time: AM PM | Began Shift: AM PM
23. Location of Accident: Town or City | State
24. Machine or tool involved in the accident:
25. Was it defective? ☐ Yes ☐ No
26. On employer's premises? ☐ Yes ☐ No
If yes, name of department:
27. Object or substance directly causing injury:
28. Describe what employee was doing:
Was this the employee's regular occupation? ☐ Yes ☐ No
29. How did accident occur? Describe events leading up to the accident:
30. Can the employer prevent this type of accident? ☐ Yes ☐ No | If yes, describe how.
31. Was safety equipment, such as goggles or guards, etc. provided? ☐ Yes ☐ No
32. Could the injured have prevented this type of accident? ☐ Yes ☐ No | If yes, describe how (do not say "By being more careful".
33. If safety equipment was provided, was it being used? ☐ Yes ☐ No

INJURY

34. Describe the injury and the part of the body injured.
35. Was this a first-aid only injury: ☐ Yes ☐ No
36. Any Lost Time? ☐ Yes ☐ No | If yes, date disability began | Last date paid in full:
37. Employee returned to work? ☐ Yes ☐ No | If yes, date | At what weekly wage:
38. Did injury result in death? ☐ Yes ☐ No | If yes, date of death.
39. If death, name and address of nearest relative. | Relationship
40. Name and address of Physician
41. Name and address of Hospital:
Remained Overnight ☐ Yes ☐ No

INS

42. Workers' Compensation Insurance Carrier. Do NOT give your insurance agent's name.
Name in full: Policy No.
Signed by:
Employer or Representative | Title | Date

___Provided Form 8 ___Dept. of Labor ___Ins. Co. ___ Employer ___Employee

Equal Opportunity is the Law