



EMPLOYEE'S CLAIM AND EMPLOYER FIRST REPORT OF INJURY

State File No. _____

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's Social Security Number MUST be provided.

E M P L O Y E R	1. Legal Name:			2. Business Name:			
	3. Mail Address: No. and Street		City		State	Zip	
	4. Location (if different from Mail Address):					Federal ID No.	
	5. Nature of Business (list principal products or service of concern):				Do you regularly employ 10 or more employees? <input type="checkbox"/> Yes <input type="checkbox"/> No		Telephone No.
E M P L O Y E	6. Name: First Name		Middle Initial	Last Name		8. Social Security No.	
	7. Home Address: No. and Street		Telephone No.	10. Job Title:		9A. Age	
	City		State	Zip	12. Dept. assigned to:		11. Sex <input type="checkbox"/> M <input type="checkbox"/> F
E E	13. Wages \$ Per	Hours Per Day Days Per Week	14. If board, lodging, etc. were furnished in addition to wages, state estimated value: \$		15. Was employee hired in VT? <input type="checkbox"/> No <input type="checkbox"/> Yes		16. Date of Hire
	17. Date of Accident:	Accident Time a.m. p.m.	Began Shift a.m. p.m.		20. Machine or tool involved in the accident:		
C C	18. Location of Accident:	Town or City		State	21. Was it defective? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe how.		
	19. On employer's premises? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of dept.:				22. Object or substance directly causing injury:		
I D E N T I F Y	23. Describe what employee was doing:					Was this the employee's regular occupation? <input type="checkbox"/> No <input type="checkbox"/> Yes	
	24. How did accident occur? Describe events leading up to the accident.						
	25. Can the employer prevent this type of accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe how.						
	26. Was safety equipment, such as goggles or guards, etc. provided? <input type="checkbox"/> No <input type="checkbox"/> Yes						
T	27. Could the injured have prevented this type of accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe how (do not say, "By being more careful.").						
	28. If safety equipment was provided, was it being used? <input type="checkbox"/> No <input type="checkbox"/> Yes						
I N J U R Y	29. Describe the injury and the part of body injured.						
	30. Any Lost Time? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, date disability began.	Last date paid in full:	31. Employee returned to work? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, date returned.	At what weekly wage: \$	
	32. Did injury result in death? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, date of death.	33. If death, name and address of nearest relative.			Relationship	
	34. Name and Address of Physician						
	35. Name and Address of Hospital					Remained overnight? Yes <input type="checkbox"/> No <input type="checkbox"/>	
I N S	36. Workers' Compensation Insurance Carrier. Do NOT give your insurance agent's name.						
	Name in full:				Policy No.		
	Signed by:						
Employer or Representative			Title		Date		