VERMONT

DEPARTMENT OF LABOR – ATTN: WORKERS' COMPENSATION
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

Form 1 (Rev. 9/11)
(Approved for use as OSHA 101 and 301)

State File No. _____

EMPLOYER FIRST REPORT OF INJURY

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. Telephone Number, Extension and Contact Person.:
6. Nature of Business (list principal products or service of concern):	7. Do you regularly employ 10 or more employees? ☐ Yes ☐ No	8. Federal ID 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. Home Phone No.:	14. Work Phone No:		15. Age:
City	State	Zip	16. Job Title:		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, tool, object, motor vehicle or substance directly causing injury:			
25. On employer's premises? ☐ Yes ☐ No	If yes, name of department:		
26. Describe what employee was doing:	Was this the employee's regular occupation? ☐ Yes ☐ No		
27. How did accident occur? Describe events leading up to the accident:			

INJURY

28. Describe the injury and the part of the body injured.				**29. Was this a first-aid only injury:** ☐ Yes ☐ No	
30. Any Lost Time? ☐ Yes ☐ No	If yes, date disability began	Last date paid in full:	31. Employee returned to work? ☐ Yes ☐ No	If yes, date	Medical Only Incident: Yes ☐ No ☐
32. Did injury result in death? ☐ Yes ☐ No	If yes, date of death.				
33. Name and address of Physician:					
34. Name and address of Hospital:			Remained Overnight ☐ Yes ☐	No	

INS

35. Insurance Company Named on Workers' Compensation Policy	35A. Claim Administrator
Name in full: _____	Company Name _____
Policy No.	Phone Number
Signed by: _____	
Employer or Representative	Title Date

Equal Opportunity is the Law