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

DEPARTMENT OF LABOR

Employer's Liability and Workers' Compensation

NOTICE TO EMPLOYEES

This employer, ____ , has complied with the provisions of Title 21 of the Vermont Statutes, Annotated §687, by obtaining Workers' Compensation Insurance coverage through:

____

(Insurance Carrier)

Workers' Compensation benefits for lost time, medical expenses, disability or death because of a work-related injury are available through the above named company.

- **An injured employee MUST immediately notify his/her employer of an injury.**
- **The employer MUST file an Employee Claim and Employer's First Report of Injury (Form 1) with the Vermont Department of Labor within 72 hours of the notice of an injury that requires medical attention or results in time lost from work. The employer must also provide a copy of the Form 1 to the injured worker and to the insurance carrier.**
- **If the employer fails to file a First Report, an employee may file a Notice of Injury and Claim for Compensation (Form 5) with the Vermont Department of Labor within six months of the date of injury.**
- **Information concerning injured worker rights and benefits is available on the department's Workers' Compensation website at http://www.labor.vermont.gov or by calling (802) 828-2286.**

Equal Opportunity is the Law
The State of Vermont is an Equal Opportunity/Affirmative Action Employer. Applications from women, individuals with disabilities, and people from diverse cultural backgrounds are encouraged. Auxiliary aids and services are available upon request to individuals with disabilities. 711 (TTY/Relay Service) or 802-828-4203 TDD (Vermont Department of Labor).