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

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

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