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

INJURY

27. How did accident occur? Describe events leading up to the accident:
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
Name in full: _____
Policy No.
35A. Claim Administrator
Company Name _____
Phone Number

Signed by: _____
Employer or Representative | Title | Date

Equal Opportunity is the Law

Mail to:

DOL Form 8 Rev. 9/11

Insurance Carrier Name: _____ State File No. _____

Insurance Carrier Address: _____ Ins. Co. File No. _____

Insurance Carrier City/State/Zip: _____ Date of Injury _____

Insurance Carrier Adjuster: _____

NOTICE OF INTENT TO CHANGE HEALTH CARE PROVIDER

Note: An employee has the right to change health care providers from the one suggested or assigned to them by their employer, **regardless** of the reasons for the change, at **any time** during the course of treatment after the first appointment.

Employee Name: _____

Address: _____

City/State/Zip: _____ Home Telephone: _____

E-mail Address: _____ Work Telephone: _____

I am changing my medical care for my work-related injury from the first treating health care provider selected by my employer to the provider of my choice.

FIRST TREATING PROVIDER

Name: _____

Address: _____

City/State/Zip: _____

NEW TREATING PROVIDER

Name: _____

Address: _____

City/State/Zip: _____

I am changing because:

- ☐ I would rather treat with my family health care provider.
- ☐ I believe another health care provider is better able to treat my symptoms.
- ☐ I have previously treated with another health care provider.
- ☐ Other (please describe below):

_____

This notice should be presented to the employer/insurance carrier prior to changing health care providers to fulfill the requirements of Vermont law, [21 V.S.A. § 640(b)]. Notice is not required for subsequent changes of provider after the first change of provider form is submitted.

_____

Print Employee Name

_____ _____

Employee Signature Date

VERMONT Workers' Compensation Division, PO Box 488, Montpelier, VT 05601-0488