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**

State of Vermont
Department of Labor
Workers' Compensation Division
PO Box 488
Montpelier, VT 05601-0488

State File No. _____

# EMPLOYEE'S NOTICE OF INJURY AND CLAIM FOR COMPENSATION

**Employee:**

Name: _____
Street: _____
City: _____
State: _____ Zip: _____
DOB: _____
Social Security No.: _____
Home Telephone Number: _____
Work Telephone Number: _____
Email Address: _____

**Employer:**

Legal Name: _____
D/B/A: _____
Street: _____
City: _____
State: _____ Zip: _____
Owner/Supervisor Name: _____
Telephone Number: _____

**Injury:**

Date of Injury: _____
Job Site Location: _____
Body Part Injured: _____
Machine or Tool Involved: _____
Did you notify your employer/supervisor at the time of the injury/illness? ☐ No ☐ Yes – Date: _____
Briefly explain how injury/illness occurred:

_____

EMPLOYEE SEEKS COMPENSATION FOR:
Lost Time Benefits: _____ Medical Benefits: _____ Both: _____
If you lost time from work, indicate period of lost time From: _____ To: _____
Dependency Benefits:

| Name of Dependent | Date of Birth | Relationship |
|---|---|---|
| | | |
| | | |
| | | |

**In all cases to facilitate the processing of this claim please attach all supporting medical documentation.**

_____ _____
Employee Signature Date Signed Attorney Signature (if represented) Date Signed

**Employee's Notice of Injury and Claim For Compensation (Form 5)**

**INSTRUCTION SHEET**

In workers' compensation claims the **injured worker has the burden of proving that his or her injuries are work related.** The injured worker must demonstrate through medical evidence the extent of the injuries and disability as well as the causal relationship to the work injury. In order to process your claim for workers' compensation benefits **you MUST provide the following information:**

1. Complete the attached Employee's Notice of Injury and Claim For Compensation (Form 5). If you are claiming lost time from work, please also complete the attached Certificate of Dependency and Employee Exemption Report (Form 10/10s).

2. Enclose copies of relevant medical records. This is required to process your claim. Check off and attach any of the relevant medical records noted below:

___ treatment notes from each office visit you had with any medical provider
___ emergency room records
___ radiology reports (not films)
___ chiropractic records
___ physical therapy notes
___ written clarification from your treating providers as to whether they feel your condition is work-related (strongly recommended).

3. List names of any witnesses to your injury or persons involved in your accident. If possible, include contact information and attach written statement which are signed and dated.
_____

4. Answer the following questions (attach additional sheets if necessary)
What are your present symptoms? _____
Where did you first receive treatment? _____on what date?_____
Who chose the first treating medical provider? ____ you ___ employer
Who is currently providing treatment to you? _____
When is your next appointment date? _____ with whom?_____
Have you returned to work? ___yes ___ no - if yes, on what date? _____
Are you working your regular hours? ___yes ___no - if no, hours working _____

**Return this instruction sheet with the Form 5 and Form 10 to the Dept. address above.**

It is recommended that you keep copies of all submitted information for your records. If you are still receiving treatment for your injury/illness you should continue to provide updated medical records to the insurance company and this office until a decision is made on your claim.

DOL Form 4 Rev 9/11

**Department of Labor**
**Workers' Compensation Division**
**PO Box 488**
**Montpelier, VT 05601-0488**
**(802) 828-2286**

State File No. _____
Ins. Co. File No. _____
Date of Injury _____
Soc. Sec. No. _____

# REPORT OF FATAL ACCIDENT

**IMPORTANT:** This report is to be used only when a work related injury results in a fatality. In all such cases, the Employer's First Report of Injury (Form 1) also must be filed.

1. Name of Employer: _____
2. Address of Employer: _____
3. Nature of Business: _____
4. Name of Injured Person: _____
5. Residence of Injured Person at Time of Death: _____
6. Date of Accident: _____
7. Date of Death: _____
8. Place where Injured Person Died: _____
9. ☐ Single ☐ Married ☐ Civil Union ☐ Widower ☐ Widow ☐ Divorced
10. Number of Children under Eighteen years of age: _____
11. If no Spouse or Reciprocal Beneficiary or Children Survive, State Other Relatives Dependent Upon Deceased: _____
12. Relationship of Dependents: _____

Dated this _____ day of _____ 20 _____ (year)

_____
Employer

By _____
Official Position

Vermont Department of Labor
Workers' Compensation
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

Form 10 (rev 9/11)

State File # _____
Ins. Co. File # _____
Date of Injury _____

www.labor.vermont.gov

## Certificate of Dependency and Concurrent Employment

Employee: _____

Employer: _____

TO THE EMPLOYEE: This form MUST be completed in every workers' compensation case in which an injured worker has lost time from work as the result of a work-related injury. The form must be completed even when the injured worker has no dependents. The information must be supplied and the form signed by the injured worker. This information is required to determine the employee's right to additional weekly compensation of $10.00 for each dependent child under the age of twenty-one (21) years.

List below your dependent child(ren) up to 21 years old that have not already been declared by your spouse on his/her current workers' compensation claim.**

| Name of Dependent | Date of Birth | Relationship |
|---|---|---|
| | | |
| | | |
| | | |

Concurrent employment: If you were working for more than one employer on the date of injury indicated above please provide the following information.**

| Name of Employer | Employer's Address | Employer's Phone Number | Date of Hire |
|---|---|---|---|
| | | | |
| | | | |

I hereby certify that the above is a true, complete and accurate statement of my dependents and concurrent employment.

Employee Signature _____ Date Signed _____ Address _____

Telephone Number _____ City/State/Zip _____

**Attach additional sheets if necessary and return this to the insurance carrier

Department of Labor, Workers' Workers' Compensation
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286; TDD 800-650-4152
www.labor.vermont.gov

DOL FORM 25 (Rev. 1/2018)

State File No. _____
Ins. Co. File No. _____
Date of Injury _____
Fed. ID No. _____

# WAGE STATEMENT – For injuries occurring on or after July 1, 2008

Employee: _____

Employer: _____

Wage Rate: $ _____ per _____ Number of Days Hired to Work: _____ Number of Hours Hired to Work: _____

| | Week Ending | | | Number of Hours or Days Worked | Gross Wages | Extras (as in 6 or 7) Please indicate what the extra is, for example, $1000.00 bonus |
|---|---|---|---|---|---|---|
| | Month | Day | Year | | | |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |
| 11 | | | | | | |
| 12 | | | | | | |
| 13 | | | | | | |
| 14 | | | | | | |
| 15 | | | | | | |
| 16 | | | | | | |
| 17 | | | | | | |
| 18 | | | | | | |
| 19 | | | | | | |
| 20 | | | | | | |
| 21 | | | | | | |
| 22 | | | | | | |
| 23 | | | | | | |
| 24 | | | | | | |
| 25 | | | | | | |
| 26 | | | | | | |

**INSTRUCTIONS:**
**Read Carefully**

1. Enter **GROSS** wages of employee for 26 weeks before date of accident (**NOT take-home pay**).
2. Do not include the week of the accident.
3. Leave blank those weeks in which the employee had excused absences for which he/she was paid for less than ½ of a work week.
4. Leave blank those weeks in which you had reduced operations or a plant shutdown and for which the employee was paid for less than ½ of a work week.
5. Do not enter those weeks in which an employee was on vacation for more than ½ of a work week.
6. If room, board, lodging or other "extras" (electricity, fuel, etc.) are provided in addition to monetary wages, break these down into a weekly value, and include and describe the income in the column marked "EXTRAS." This includes tips if not included in gross wages.
7. Include any bonuses and commissions paid to the employee in addition to wages in the column marked "EXTRAS."
8. Enter the dates when your normal work week ends (not the date a check is issued to the employee) and the number of hours or days worked.

When did the employee begin losing time? _____ Was the employee paid in full for the day of the accident? _____

Are employee's wages subject to any child support withholding order? ☐Yes ☐No
If yes, in what amount? $ _____ per _____

**Day of the week the check will be mailed to the claimant or deposited in the claimant's account** _____

This is a correct statement of the employee's earnings as taken from the employer's payroll records.

By: _____ Position Title: _____
Signature of Preparer

Print Name: _____ Date: _____

Mail to:

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