



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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		21. Date of Hire	
ACCIDENT	22. Date of Accident:		Accident Time: AM PM		Began Shift: AM PM		23. Location of Accident: Town or State City	
	24. Machine, tool, object, motor vehicle or substance directly causing injury:							
	25. On employer’s premises? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, name of department:			
	26. Describe what employee was doing:				Was this the employee’s regular occupation? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	30. Any Lost Time? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date disability began		Last date paid in full:		31. Employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	32. Did injury result in death? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date of death.					
	33. Name and address of Physician:							
34. Name and address of Hospital:						Remained Overnight <input type="checkbox"/> Yes <input type="checkbox"/> 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		