



96 Cricket Hill Road
Hyde Park, VT 05655
(802) 888-3142

PROCEDURES FOR WORKPLACE INJURIES

When an injury occurs, employees should always report the incident to their supervisor IMMEDIATELY. The supervisor or school nurse should administer first aid if needed.

If medical attention is needed, the employee should go to the emergency room at the nearest hospital or to their regular doctor if it is not an emergency.

If the injury is life threatening, call 911 immediately.

A "first report of injury" report needs to be completed online by the nurse, administrator or the administrative assistant. If for some reason there is no one available to enter the claim online, please complete the form found on the back of this notice and leave it for the administrative assistant.

Employees need to know the following regarding the claims process:

- Medical certification is required as follows:
 - At the time of the injury, stating any restrictions or accommodations if necessary.
 - Periodically during time out of work.
 - Before you return to work, stating any restrictions or accommodations if necessary.
- The employee is expected to cooperate with their medical provider, the employer and workers' compensation regarding required treatment, work restrictions, accurate reporting and timely response.
- The employee is entitled to have all reasonable medical expenses paid that were a result of the injury or illness if the workers' compensation claim is approved.
- Travel (mileage) to and from medical treatment may be reimbursable through worker's compensation insurance if the claim is approved.
- The employee will make an effort to schedule appointments relating to the injury outside of work hours. If that is not possible, worker's compensation insurance may reimburse the employee for their time away for work injury related appointments. When an employee requests leave time for a worker's compensation related appointment it needs to be noted on the request form that it is workers' compensation related.
- An employee can use up to three sick days (if available) while worker's compensation is processing the claim.

Worker's compensation insurance company is: VSBIT-Multiline, 52 Pike Drive, Berlin, VT 05602
Contact is: Timothy Vincent (802) 223-6132



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.

E M P L O Y E R	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.:	
E M P L O Y E E	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
A C C I D E N T	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? ☐ 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:							
I N J U R Y	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:						
I N S	34. Name and address of Hospital:					Remained Overnight ☐ Yes ☐ No	
	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