



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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.:
	12. Home Address: No. and Street			13. Home Phone No.:	14. Work Phone No.:	15. Age:
	City		State	Zip	16. Job Title:	
	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
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? <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:						
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: <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		
I N S	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	