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

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		**NEW TREATING PROVIDER**	
Name:	____________	Name:	____________
Address:	____________	Address:	____________
City/State/Zip:	____________	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):

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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.

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Print Employee Name

______________________ ______________________
Employee Signature Date

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