STATE OF VERMONT
DEPARTMENT OF LABOR AND INDUSTRY
Drawer 20
Montpelier, VT 05620-3401

Form 1 (Rev. 12/00)
(Approved for use as OSHA 101)

State File No.

EMPLOYEE'S CLAIM AND EMPLOYER FIRST REPORT OF INJURY

Complete form in ink or typewriter and send original to the Commissioner of Labor and Industry within 72 hours of accident. Send duplicate to your workers' compensation insurance company, give Employee's copy to employee and retain Employer's copy for your files. Answer every question fully and report promptly to avoid a penalty. Employer's Federal ID Number and Employee's 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): | **Federal ID No.**

5. Nature of Business (list principal products or service of concern): | Do you regularly employ 10 or more employees? ☐ Yes ☐ No | Telephone No.

EMPLOYEE

6. Name: First Name Middle Initial Last Name | 8. **Social Security No.** | 9. Date of birth:

7. Home Address: No. and Street | Telephone No. | 10. Job Title: | 9A. Age

City or Town State Zip | 12. Dept. assigned to: | 11. Sex ☐ M ☐ F

13. Wages $ Per | Hours Per Day Days Per Week | 14. If board, lodging, etc. were furnished in addition to wages, state estimated value: $ | 15. Was employee hired in VT? ☐ No ☐ Yes | 16. Date of Hire

ACCIDENT

17. Date of Accident: | Hour a.m. p.m. | 20. Machine or tool involved in the accident:

18. Location of Accident: Town or City State | 21. Was it defective? ☐ No ☐ Yes If yes, describe how.

19. On employer's premises? ☐ No ☐ Yes If yes, name of dept.: | 22. Object or substance directly causing injury:

23. Describe what employee was doing: | Was this the employee's regular occupation? ☐ No ☐ Yes

NATURE

24. How did accident occur? Describe events leading up to the accident.

25. Can the employer prevent this type of accident? ☐ No ☐ Yes If yes, describe how.

26. Was safety equipment, such as goggles or guards, etc. provided? ☐ No ☐ Yes

27. Could the injured have prevented this type of accident? ☐ No ☐ Yes If yes, describe how (do not say, "By being more careful.").

28. If safety equipment was provided, was it being used? ☐ No ☐ Yes

INJURY

29. Describe the injury and the part of body injured.

30. Any Lost time? ☐ No ☐ Yes | If yes, date disability began. | Last date paid in full: | 31. Employee returned to work? ☐ No ☐ Yes | If yes, date returned. | At what weekly wage? $

32. Did injury result in death? ☐ No ☐ Yes | If yes, date of death. | 33. If death, name and address of nearest relative. | Relationship

34. Name and Address of Physician

35. Name and Address of Hospital

INSURANCE

36. Workers' Compensation Insurance Carrier. Do NOT give your insurance agent's name.

Name in full: | Policy No.

Signed by:

Employer or Representative Title Date

Provided Form 8 Labor & Industry Ins. Co. Employer Employee

DOL FORM 8 (Rev 12/98)

State File No.

Ins. Co. File No.

Date of Injury

Fed. I.D. No.

STATE OF VERMONT

DEPARTMENT OF LABOR AND INDUSTRY
WORKERS' COMPENSATION DIVISION

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: SOCIAL SECURITY NO.:

ADDRESS:

CITY/STATE: 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:

NEW TREATING PROVIDER:

NAME:

ADDRESS:

CITY/STATE:

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