

DEPARTMENT OF LABOR - ATTN: WORKERS' COMPENSATION PO Box 488 Montpelier, VT 05601-0488

(802) 828-2286

State File No.		

(Approved for use as OSHA 101 and 301)

Form 1 (Rev. 9/11)

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.

Е	1. Legal Name:				2. Business								
M	3. Mail Address: No. and Street				Name: City State Zip								
P L	,												
O Y	4. Location (if different from Mail Address):				5. Telephone Number, Extension and Contact Person.:								
E	6. Nature of Business (list principal products or service of 7				7. Do you regularly employ 10 or more				r more	8. Federal ID No.:			
R	concern):					employees?							
	9. Name: First Name Middle Initial			Last Nar	Yes T			No 10. Social Security No.:		11. Date of Birth:			
E M P L	7. Ivame. That Ivame Wilder Initial		Lust I turne			10. 500		Social Security 110		Tr. Bute of Birtin.			
	12. Home Address: No. and Street				13.	13. Home Phone No.: 14			14. Work Phone No:		15. Age:		
	City		State		Zip	16.	Job Title:			17. Sex:			
Y E	18. Wages \$ Hours Per Day 19. If b			19. If bo	ard,	d, lodging, etc. were 20			20. W	0. Was employee hired in 21. Date of Hire			
E				furnishe estimate		n addition to was							
	Per	Days Per V		\$						Yes	□ No		
A	22. Date of Accident:	Accident T	Time:	Began S	Began Shift: 23. Location of Accident: Town or State City								
C		AM PM AM PM											
C I	24. Machine, tool, object, motor vehicle or substance directly causing injury:												
D E	25. On employer's premises?												
N	26. Describe what employee was doing:					Was this the employee's regular occupation? Yes No							
T													
	27. How did accident occur? Describe events leading up to the accident:												
	28. Describe the injury and the part of the body injured.								29. Was this a first-aid only injury:				
I N									Yes				
J	30. Any Lost Time?			Last date paid is full:		in 31. Employee re work?		returned to		If yes, date	Me	dical Only Incid	ent:
U R	☐ Yes ☐ No				_	Yes		No		Yes	No 🗌		
Y	32. Did injury result in death? If yes, date of death.												
	33. Name and address of Physician:												
	34. Name and address of Hospital:				ľ	Remained Overnight Yes No							
I N S	35. Insurance Company Named on Workers' Compensation Policy				35A. (35A. Claim Administrator							
	Name in full:				Compa	Company Name							
b	Policy No.				Phone	Phone Number							
	Signed by:					ı							
	Employer or Representative					Title Date							