



State of Vermont
Department of Labor
Workers' Compensation Division
PO Box 488
Montpelier, VT 05601-0488

State File No. _____

EMPLOYEE'S NOTICE OF INJURY AND CLAIM FOR COMPENSATION

Employee:

Name: _____
Street: _____
City: _____
State: _____ Zip: _____
DOB: _____
Social Security No.: _____
Telephone Number: _____

Employer:

Legal Name: _____
D/B/A: _____
Street: _____
City: _____
State: _____ Zip: _____
Owner/Supervisor Name: _____
Telephone Number: _____

Injury:

Date of Injury: _____ Body Part Injured: _____
Job Site Location: _____ Machine or Tool Involved: _____
Did you notify your employer/supervisor at the time of the injury/illness? [] Yes [] No
Briefly explain how injury/illness occurred:

EMPLOYEE SEEKS COMPENSATION FOR:

Lost Time Benefits: _____ Medical Benefits: _____ Both: _____
If claimant lost time benefits, indicate period of lost time From: _____ To: _____

In either case, if claimant lost time or medical benefits, medical documentation MUST be attached.

Employee Signature

Attorney Signature

*** TO BE COMPLETED BY THE DEPARTMENT OF LABOR***

Workers' Compensation Insurance Carrier:

Policy Period: _____ To: _____
Policy Number: _____ Policy Cancelled: _____