VERMONT

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.: ____________________
Home Telephone Number: ________________
Work Telephone Number: ________________
Email Address: ________________________

Employer:

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

Injury:

Date of Injury: ____________________
Job Site Location: ____________________
Body Part Injured: ____________________
Machine or Tool Involved: ____________________

Did you notify your employer/supervisor at the time of the injury/illness? ☐ No ☐ Yes – Date: __________

Briefly explain how injury/illness occurred:

____

EMPLOYEE SEEKS COMPENSATION FOR:

Lost Time Benefits: ____________ Medical Benefits: ____________ Both: ____________

If you lost time from work, indicate period of lost time From: ____________ To: ____________

Dependency Benefits:

Name of Dependent	Date of Birth	Relationship

In all cases to facilitate the processing of this claim please attach all supporting medical documentation.

______________________________________ ______________________________________
Employee Signature Date Signed Attorney Signature (if represented) Date Signed

Employee's Notice of Injury and Claim For Compensation (Form 5)

INSTRUCTION SHEET

In workers' compensation claims the **injured worker has the burden of proving that his or her injuries are work related.** The injured worker must demonstrate through medical evidence the extent of the injuries and disability as well as the causal relationship to the work injury. In order to process your claim for workers' compensation benefits **you MUST provide the following information:**

1. Complete the attached Employee's Notice of Injury and Claim For Compensation (Form 5). If you are claiming lost time from work, please also complete the attached Certificate of Dependency and Employee Exemption Report (Form 10/10s).

2. Enclose copies of relevant medical records. This is required to process your claim. Check off and attach any of the relevant medical records noted below:

___ treatment notes from each office visit you had with any medical provider
___ emergency room records
___ radiology reports (not films)
___ chiropractic records
___ physical therapy notes
___ written clarification from your treating providers as to whether they feel your condition is work-related (strongly recommended).

3. List names of any witnesses to your injury or persons involved in your accident. If possible, include contact information and attach written statement which are signed and dated.
____

4. Answer the following questions (attach additional sheets if necessary)
What are your present symptoms? ____________________________________
Where did you first receive treatment? ________________on what date?______
Who chose the first treating medical provider? ____ you ___ employer
Who is currently providing treatment to you? ______________________
When is your next appointment date? _______ with whom?_______________
Have you returned to work? ___yes ___ no - if yes, on what date? _______
Are you working your regular hours? ___yes ___no - if no, hours working _____

Return this instruction sheet with the Form 5 and Form 10 to the Dept. address above.

It is recommended that you keep copies of all submitted information for your records. If you are still receiving treatment for your injury/illness you should continue to provide updated medical records to the insurance company and this office until a decision is made on your claim.