DOL Form 4 Rev 9/11

Department of Labor
Workers' Compensation Division
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

State File No. _____
Ins. Co. File No. _____
Date of Injury _____
Soc. Sec. No. _____

REPORT OF FATAL ACCIDENT

IMPORTANT: This report is to be used only when a work related injury results in a fatality. In all such cases, the Employer's First Report of Injury (Form 1) also must be filed.

1. Name of Employer: _____
2. Address of Employer: _____
3. Nature of Business: _____
4. Name of Injured Person: _____
5. Residence of Injured Person at Time of Death: _____
6. Date of Accident: _____
7. Date of Death: _____
8. Place where Injured Person Died: _____
9. ☐ Single ☐ Married ☐ Civil Union ☐ Widower ☐ Widow ☐ Divorced
10. Number of Children under Eighteen years of age: _____
11. If no Spouse or Reciprocal Beneficiary or Children Survive, State Other Relatives Dependent Upon Deceased: _____
12. Relationship of Dependents: _____

Dated this _____ day of _____ 20 _____ (year)

_____
Employer

By _____
Official Position