VERMONT
VERMONT DEPARTMENT OF LABOR

www.labor.vermont.gov

WORKERS COMPENSATION DIVISION
5 GREEN MOUNTAIN DRIVE, PO BOX 488
MONTPELIER, VT 05601-0488
(802) 828-2286

Form 25M Rev. 1/15

State File No.: _____
Ins. Co. File No.: _____
Date of Injury: _____

This form shall be filed whenever a claimant has received or is eligible to receive 90 days of temporary total disability [see Title 21 §641(a)(3)]. These are not consecutive days but cumulative. Failure to file this form promptly and accurately may result in administrative sanctions pursuant to Rule 45.000. In lieu of a screening a referral for vocational rehabilitation entitlement may be filed. This form MUST be filed with a copy of the referral form (VR1).

MEMORANDUM OF PAYMENT

Employee

Last Name: First Name:

Mailing Address: City: State: Zip:

Telephone Number:

Employer

Employer Name: Employer Telephone Number:

Employer Address:

Insurer:

Payment Made

Weekly Compensation
Date Disability Payment Began: _____ Weekly Amount Paid: _____
Total Amount of Indemnity Paid To Date: _____
Other: (Please Explain)

ISSUED BY:

Carrier: _____ Administrator (if not carrier): _____
Adjuster Name: _____ Telephone No.: _____
Adjuster Signature: _____ Adjuster's Employer: _____
Adjuster License #: _____

☐ Vocational Rehabilitation Referral filed with: _____
Name of Vocational Rehabilitation Counselor

Company Responsible for Payment: _____

Mailing Address: City: State: Zip: