



State File No. \_\_\_\_\_

**EMPLOYEE'S CLAIM AND EMPLOYER FIRST REPORT OF INJURY**

Complete form in ink or typewriter and send original to the Commissioner of Labor and Industry within 72 hours of accident. Send duplicate to your workers' compensation insurance company, give Employee's copy to employee and retain Employer's copy for your files. Answer every question fully and report promptly to avoid a penalty. Employer's Federal ID Number and Employee's Social Security Number MUST be provided.

E M P L O Y E R	1. Legal Name: University of Vermont and State Agricultural College			2. Business Name: University of Vermont and State Agricultural College		
	3. Mail Address: No. and Street 250 Colchester Ave.		City Burlington	State VT	Zip 05405	
E M P L O Y E	4. Location (if different from Mail Address): same					Federal ID No. 030179440
	5. Nature of Business (list principal products or service of concern): higher education				Do you regularly employ 10 or more employees? x Yes <input type="checkbox"/> No	
E M P L O Y E	6. Name: First Name		Middle Initial	Last Name		8. Social Security No.
	7. Home Address: No. and Street			Telephone No.	10. Job Title:	
E M P L O Y E	City or Town		State	Zip		12. Dept. assigned to:
	13. Wages \$ Per		Hours Per Day Days Per Week	14. If board, lodging, etc. were furnished in addition to wages, state estimated value: \$		15. Was employee hired in VT? <input type="checkbox"/> No <input type="checkbox"/> Yes
A C C I D E N T	17. Date of Accident:		Accident Time a.m. p.m.	Began Shift a.m. p.m.	20. Machine or tool involved in the accident:	
	18. Location of Accident:		Town or City	State	21. Was it defective? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe how.	
I N J U R Y	19. On employer's premises? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of dept.:			22. Object or substance directly causing injury:		
	23. Describe what employee was doing:					Was this the employee's regular occupation? <input type="checkbox"/> No <input type="checkbox"/> Yes
D E S C R I B E	24. How did accident occur? Describe events leading up to the accident.					
	25. Can the employer prevent this type of accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe how.					
N E E D E D	26. Was safety equipment, such as goggles or guards, etc. provided? <input type="checkbox"/> No <input type="checkbox"/> Yes					
	27. Could the injured have prevented this type of accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe how (do not say, "By being more careful.").					
E M P L O Y E	28. If safety equipment was provided, was it being used? <input type="checkbox"/> No <input type="checkbox"/> Yes					
	29. Describe the injury and the part of body injured.					
I N J U R Y	30. Any Lost Time? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, date disability began.	Last date paid in full:	31. Employee returned to work? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, date returned.
	32. Did injury result in death? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, date of death.	33. If death, name and address of nearest relative.		
R E L A T I V E	34. Name and Address of Physician					
	35. Name and Address of Hospital				Remained overnight? Yes <input type="checkbox"/> No <input type="checkbox"/>	
I N S U R E	36. Workers' Compensation Insurance Carrier. Do NOT give your insurance agent's name. Midwest Employers Casualty Company					
	Name in full: Midwest Employers Casualty Company				Policy No. EWC007321	
S I G N E D	Signed by:					
	Employer or Representative		Title		Date	

\_\_\_ Provided Form 8    \_\_\_ Dept. of Labor    \_\_\_ Ins. Co.    \_\_\_ Employer    \_\_\_ Employee