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

Form 10 (rev 9/11)

State File # _____
Ins. Co. File # _____
Date of Injury _____

www.labor.vermont.gov

Certificate of Dependency and Concurrent Employment

Employee: _____

Employer: University of Vermont

TO THE EMPLOYEE: This form MUST be completed in every workers' compensation case in which an injured worker has lost time from work as the result of a work-related injury. The form must be completed even when the injured worker has no dependents. The information must be supplied and the form signed by the injured worker. This information is required to determine the employee's right to additional weekly compensation of $10.00 for each dependent child under the age of twenty-one (21) years.

List below your dependent child(ren) up to 21 years old that have not already been declared by your spouse on his/her current workers' compensation claim.**

Name of Dependent	Date of Birth	Relationship

Concurrent employment: If you were working for more than one employer on the date of injury indicated above please provide the following information.**

Name of Employer	Employer's Address	Employer's Phone Number	Date of Hire

I hereby certify that the above is a true, complete and accurate statement of my dependents and concurrent employment.

Employee Signature _____ Date Signed _____ Address _____

Telephone Number _____ City/State/Zip _____

**Attach additional sheets if necessary and return this to the insurance carrier