



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: _____ Body Part Injured: _____
Job Site Location: _____ 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:

Table with 3 columns: 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.