EMPLOYER'S FIRST REPORT AND EMPLOYEE'S NOTICE OF INJURY
OR OCCUPATIONAL ILLNESS
VI DEPARTMENT OF LABOR, DIVISION OF WORKER'S COMPENSATION
ST. THOMAS AND ST. CROIX

CASE NUMBER (NOT TO BE FILLED BY EMPLOYER)

EMPLOYER

1. Employer (Company Name)	2. OSHA Case or File Number
3. Mail Address (No., Street, City, Zip)	4. V.I.E.S.A. Account Number
5. Employer's Location if Different From Mailing Address	6. Insurance Policy Number
7. Nature of Business, Products Manufactured (Construction, Trade, Etc.)	8. Number of Employees

EMPLOYEE

9. Employee's Name (First, Middle, Last)	10. Social Security Number	11. Age D.O.B.	12. Sex
13. Employee's **Mailing Address** (No., Street, City or P.O. Box, Zip)	14. How Long Employed?	15. Nationality?	
16. Occupation	17. Department in which Employed	18. Name of Supervisor	
19. Hours Worked Per Week	20. Days Per Week	21. Wage Per Hour	22. Salary per Wk/Mo.	23. If other Advantages Are Provided, Estimate Value Per Wk/Mo. (Specify)

ACCIDENT OR EXPOSURE

24. Place of Accident or Exposure (Address and Location)	25. State if Employer's Premises	26. Department	
27. Date of Injury	28. Day of Week	29. Time of Day _____ AM _____ PM	30. Date Supervisor First Knew of Occurrence	31. Did Employee Die?
32. Date Disability Began or Occupational Illness Became Evident	33. Time of Day _____ AM _____ PM	34. Was Insured Paid in Full This Day?	35. Time of Day Employee Begins Work

36. Activity of Employee at Time of Accident or Exposure (Be specific: If Using Tools or Equipment or Handling Materials. Name them and Tell What Employee was doing with them)

37. TYPE OF ACCIDENT that Occurred (Describe Events Fully: Name Objects or Substances Involved and How They Were Involved and How They were Involved: Give Full Details On All Contributory Factors)

38. Name and Addresses of Witnesses

39. SOURCE OF INJURY or Occupational Illness (Name Object Struck or Struck By: Vapor, Poison, Chemical; If Strain or Hernia, Name Thing Lifted or Pushed; If solely From Bodily Motion, Describe Twisting Resulting in Injury; Etc.)

INJURY OR OCCUPATIONAL ILLNESS

40. NATURE OF INJURY or Occupational Illness and PART OF BODY Affected (E.G., Amputation of Right Index Finger, Lead Poisoning, Inflammation of Left Eye)

41. Name and Address of Treating Practitioner	42. If Hospitalized, Name and Address of Hospital		
43. If Employee Returned to Work, Give Date and Hour	44. At What Wage?	45. At What Occupation	46. Was Case Recorded on OSHA Long 200S

SIGNATURES

REPORT PREPARED BY (PRINT OR TYPE NAME)	POSITION	TELEPHONE NUMBER
EMPLOYER'S SIGNATURE	DATE OF EMPLOYER'S SIGNATURE	
EMPLOYEE'S SIGNATURE	EMPLOYEE'S TELEPHONE NUMBER	DATE OF EMPLOYEE'S SIGNATURE

FORM NUMBER _____

VIDSS:1-1-75