

**VI DEPARTMENT OF LABOR, DIVISION OF WORKER'S COMPENSATION  
ST. THOMAS AND ST. CROIX**

**(NOT TO BE FILLED BY EMPLOYER)**

<b>EMPLOYER</b>	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		
<b>EMPLOYEE</b>	9. Employee's Name (First, Middle, Last)				10. Social Security Number		11. Age    D.O.B.		12. Sex
	13. Employee's <u>Mailing Address</u> (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)
<b>ACCIDENT OR EXPOSURE</b>	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								
<b>INJURY OR OCCUPATIONAL ILLNESS</b>	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.)								
	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			
<b>SIGNATURES</b>	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		
	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			