GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES

DEPARTMENT OF LABOR

4401 Sion Farm- Christiansted
St. Croix, VI 00820-4245
Phone: (340) 713-3413
Fax (340) 772-3365

P. O. Box 302608
St. Thomas, VI 00803-2608
Phone: (340) 776-3700
Fax (340) 774-6801

Workers' Compensation Administration

EMPLOYEE'S CLAIM FOR COMPENSATION FOR DISABILITY

INSTRUCTIONS: Every question on this blank must be answered. Write "None" in spaces which are **not** applicable to your case. Write in ink or on typewriter. The claim must be filed within 60 days after the injury. The claim must be sworn to in the presence of a Notary Public, or before the District Director of Workers' Compensation.

NAME OF INJURED EMPLOYEE: (Please Print) _____

I hereby make claim for compensation for the injury and resulting disability described below due to an accident arising out of and in the course of my employment with _____

Name of Employer

of _____ The said injury was not caused by willful misconduct on my part or by my willful intention to injure or kill myself or another, or by my intoxication.

INJURY: Date of Accident: _____ Location of Accident: _____

If away from employer's premises, explain briefly duty which carried you there _____

_____

Describe how accident occurred: _____

_____

_____

Description of injury (indicate member of body injured) _____

_____

Is it temporary or permanent? _____ Other pertinent Information _____

_____

DISABILITY RESULTING FROM INJURY: Date disability began: Partial _____ Total _____

Are you now disabled? _____ Date disability ceased: Partial _____ Total _____

If disability was intermittent, state various periods of disability _____

_____

Date returned to work; On part pay: _____ On full pay: _____

If you have not returned to work though not now disabled, explain _____

_____

EARNINGS: Were you paid in full for the day the accident occurred? _____

If your wages continued beyond the date of accident, what was the last day for which paid? _____

What was the first day for which you received pay upon return to work? _____

If your disability was partial or intermittent, give, in detail, your earnings (rate and amount) if any, and the various periods (dates) for which you have been paid: _____

_____

Wages or average earnings before injury: Per Hour _____ Per Day _____ Per Week _____

Were you a full-time or an intermittent worker? _____ If irregular or overtime earnings involved in above, explain: _____

Wages or average earnings upon return to work: Per Hour: _____ Per Day: _____ Per Week: _____

If these differ from the earnings before injury, explain: _____

REGARDING THE INJURED EMPLOYEE: Sex _____ Age _____ Married or Single _____

How long have you worked for the employer indicated above? _____ In what occupation? _____

Were you doing your regular work when injured? _____ If not, what work? _____

REGARDING MEDICAL ATTENDANCE: What physician attended you? _____

Where? _____ If hospitalized: Name of Hospital _____ Date entered _____

Date Discharged: _____ SIGNED, This _____ day of _____ 20 ____ at _____

ACKNOWLEDGED, SUBSCRIBED AND SWORN

TO BEFORE ME THIS _____ __DAY_____ 20_____

_____

Notary Public

_____

Signature of Injured Employee

Address: _____

or _____

(Signature if person filing claim on behalf of injured employee)

Relationship to injured employee, If any _____

Mailing Address: _____

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Telephone Number _____

Form #: _____