WHAT EVERY EMPLOYEE SHOULD KNOW

What is Workers' Compensation?

Workers' Compensation is an insurance program that pays an employee's medical and disability income benefits for work-related injuries and diseases.

WHAT SHOULD AN INJURED EMPLOYEE DO IMMEDIATELY FOLLOWING AND ACCIDENT?

- Notify your employer at once. You cannot receive benefits unless your employer knows you are injured.

- Employees' must report all injuries within forty-eight (48) hours after the injury.

- Ask your employer to complete the "Employer's First Report and Employee's Notice of Injury Report" form.

- Request a "Surgeon's Report" form from your employer. The treating physician must complete this form for all initial visits.

- If time is lost from the job because of your injury, you must complete an "Employee's Claim for Compensation for Disability" form and submit it to the Division of Worker's Compensation.

SUBSECTION 258- FILING OF CLAIM (a), (b), & (c):

(a) The first claim for compensation for an injury shall be filed in writing within sixty (60) days after the injury on forms to be furnished by the Commissioner. Such claims shall be filed at the office of the Commissioner or deposited in the mail properly stamped and addressed to the Commissioner or to any person whom the Commissioner may designate. Each claim shall be sworn to by the injured person or whoever acts in his/her behalf, and shall be accompanied by a doctors' certificate stating the nature and probable extend of the disability, or by death certificate.

(b) Supplementary claims, if any, for protracted disability or for any additional compensation claimed, shall be filed in the manner directed by the Commissioner.

(c) For good and reasonable cause shown the Commissioner may extend the time limit set by this section- Amended June 12, 1961.

Title 24, Chapter 11, Subsection 257 (a) & (b)

NOTICE, BY EMPLOYEE, OF INJURY: REPORT BY EMPLOYER

(a) By personal delivery or by mail, written notice of an accidental injury shall be given by the person injured or someone in his/her behalf to the employer or any of his agents within forty (48) hours after the injury. In the case of an occupational disease notice shall be given by the person injured or someone in his/her behalf to the employer or any of his agents within thirty (30) days from the first distinct manifestation thereof. Such notice shall contain the name of the person, the nature of the injury or occupational disease, and when and where it occurred. Unless written notice of injury or occupational disease is given as above, or unless the employee's immediate superior has actual knowledge of the injury or occupational disease, compensation may be denied. For reasonable cause shown, the Commissioner may accept written notice of the injury given later than forty-eight (48) hours, but not later than thirty (30) days, after the injury and in the case of an occupational disease, the Commissioner may accept written notice given later the thirty (30) days, but not later than ninety (90) days after the first distinct manifestation thereof: which time limit for filing of reports shall also be applicable to injuries of a tuberculous origin arising out of employment.

(b) Within eight (8) days after the receipt of the written notice injury referred to in subsection (a) hereof, the employer shall complete an employer's report of injury and forward same together with the employee's notice of injury to the Commissioner by personal delivery or by mail. The failure of the employer to file such reports with such period shall not prejudice the claim of the employee.

BASIC BENEFITS AVAILABLE TO INJURED EMPLOYEES:

- Disability Income Benefits (Lost Wages)
- All injury/disease, medical expenses are paid directly to the health care provider.
- Rehabilitation Services
- Payments of Prescriptions
- Durable Medical Equipment
- Therapy and Chiropractic Services
- Other related treatment pertaining to the injury/disease.

All medical services are subject to prior written authorization.

If you have any questions, please contact or visit the Division of Workers' Compensation.

St. Thomas:
2353 Kronprindsens Gade 53A/54A&B
St. Thomas, USVI 00802
(1-340-776-3700)

St. Croix:
314 King St.
Frederiksted, St. Croix 00840
(1-340-692-9390)

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. Mailing 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.)

OCCUPATIONAL ILLNESS

40. NATURE OF INJURY or Occupational Illness or 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

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

Workmen's Compensation Form No. 2

STANDARD FORM FOR

SURGEON'S REPORT

COMMISSIONER OF LABOR
VIRGIN ISLANDS OF THE UNITED STATES

Commission's Number	File: .... Carrier: .... Employer: ....
Carrier's File No.	
(The spaces above not to be filled in by Employer)	

The Patient

1. Name of Injured Person: .... Age: .... Sex: ....
2. Address: No. and St. .... City or Town .... Virgin Islands of U.S.A.
3. Name and Address of Employer ....

The Accident

4. Date of Accident .... Hour ...... M .... Date disability began ....
5. State in patient's own words where and how accident occurred: ....

The Injury

6. Give accurate description of nature and extent of injury and state your objective findings: ....
7. Will the injury result in (a) Permanent defect? .... If so, what? ....
   (b) Facial or head disfigurement? ....
8. Is accident referred to the only cause of patient's condition? .... If not, state contributing causes ....
9. Is patient suffering from any disease of the heart, lungs, brains, kidneys, blood, vascular system or any other disabling condition not due to this accident? .... Give particulars: ....
10. Has patient any physical impairment due to previous accident or disease? .... Give Particulars: ....
11. Has normal recovery been delayed for any reason? .... Give Particulars: ....

11-b Name and type of medication prescribed for this injury ....

Treatment

12. Date of your first treatment: .... Who engaged your services? ....
13. Describe treatment given by you: ....
14. Were X-rays taken? .... By Whom? .... (Name and Address) When? ....
15. X-rays diagnosis: ....
16. Was patient treated by anyone else? .... By Whom? .... (Name and Address) When? ....
17. Was patient hospitalized? .... Name and address of hospital: ....
18. Date of admission to hospital: .... Date of discharge: ....
19. Is further treatment needed? .... For how long? ....

Disability

20. Patient was/will be able to resume work on: ....
21. Patient was/will be able to resume work on: ....
22. If death ensued give date: ....

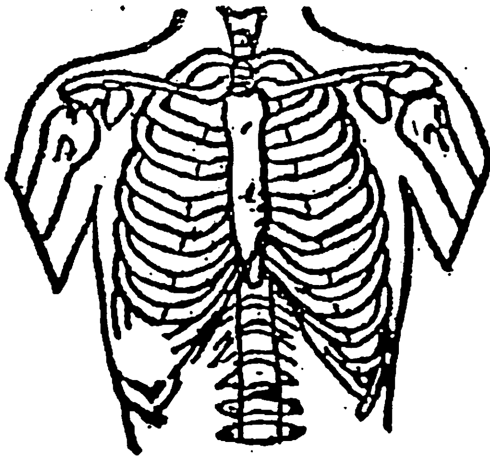
REMARKS: ...(Give an information of value not included above) ....

I am duly licensed physician in the State of ....

I was graduated from .... Medical School in .... Year ....

Date of this Report: .... Signed: ....

This Report must be signed personally by physician. Address: .... Telephone: ....



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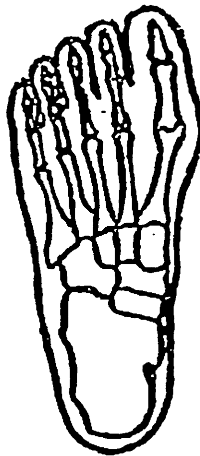

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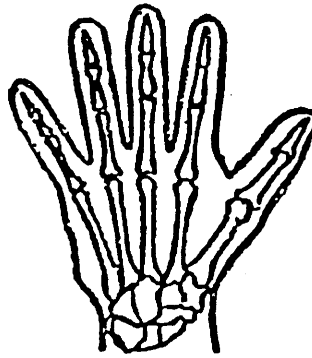
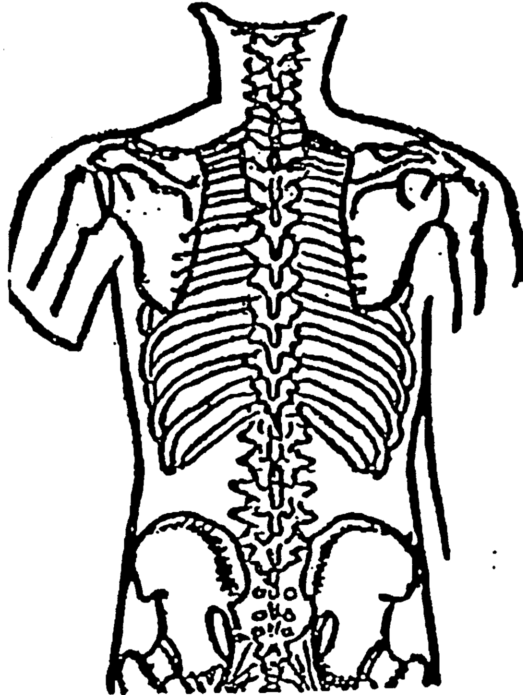


MARK FACIAL OR HEAD DISFIGUREMENT



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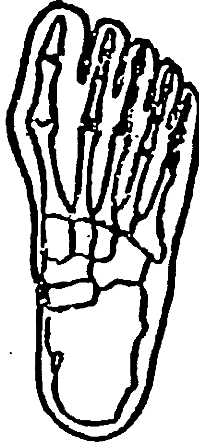

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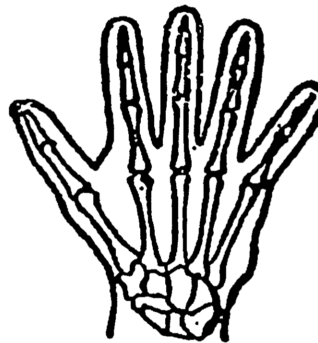
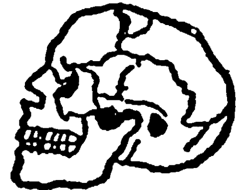
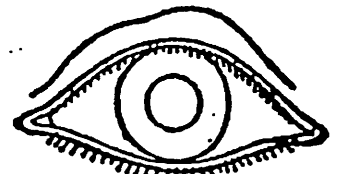
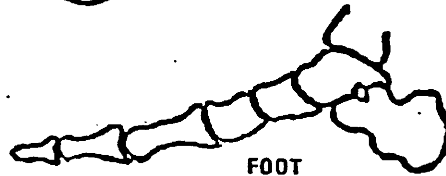




SKULL



STATE WHETHER RIGHT OR LEFT EYE



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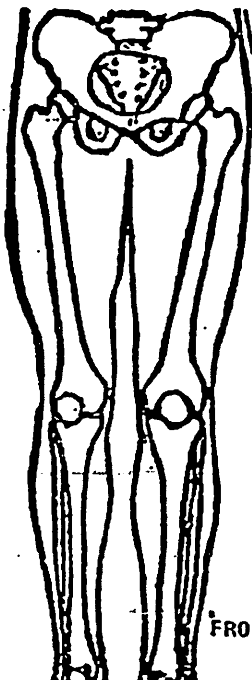

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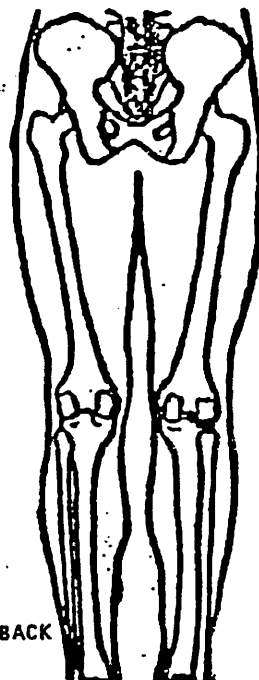

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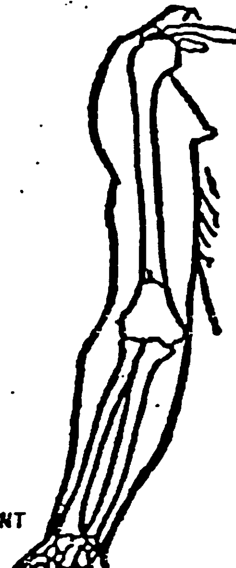
INDICATE WHETHER RIGHT OR LEFT ARM



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