EMPLOYER'S QUARTERLY WAGE & CONTRIBUTION REPORT

C-101 Web (11/04)

Vermont Department of Employment & Training
P.O. Box 488
Montpelier, Vermont 05601-0488

Please provide your business name and address in the box below.

EMPLOYER NUMBER
EMPLOYER NAME
Q-YR
QUARTER ENDING
DUE DATE

EMPLOYEE WAGE DATA FOR THIS QUARTER (Please type or print entries in BLUE or BLACK INK only)

1. SOCIAL SECURITY NUMBER	2. EMPLOYEE'S NAME (Last, First, Middle Initial)	3. TOTAL GROSS WAGES PAID THIS QUARTER	4. H/S	5. HOURLY RATE	6. GENDER M - F
7. PAGE 1 of ____ PAGE	**TOTAL WAGES THIS PAGE** ▶				

PLEASE BE SURE TO KEEP A COPY FOR YOUR RECORDS. DO NOT CUT, TAPE OR STAPLE THIS DOCUMENT.

8. For each month, report the number of covered workers who worked during or received pay for the payroll period which includes the 12th of the month.	1ST MONTH TOTAL	2ND MONTH TOTAL	3RD MONTH TOTAL	3RD MONTH FEMALE ONLY
9. Total Gross Wages Paid to all Subject Employees This Quarter				
10. Portion of Quarterly Wages from item 9 IN EXCESS of Calendar Year Limit per Employee of				
11. Taxable Wages - Subtract item 10 from item 9				
12. Contribution Tax Due (item 11) Times Your Rate of				
13. Credit Adjustment (Subject to change - See Instructions)				
14. TOTAL (Line 12 minus Line 13) If amount is negative, enter 0. **Payable to: VERMONT DEPT OF EMPLOYMENT & TRAINING**				

C-101 Web(11/04)

DEPARTMENT USE ONLY

EMPLOYER NUMBER
EMPLOYER NAME
Q-YR
QUARTER ENDING
DUE DATE

15. ☐ No longer have employees in Vermont
☐ Discontinued business in Vermont
☐ Ownership or name as shown has changed.

16. DATE

17. TELEPHONE

DEPARTMENT USE ONLY

18. SIGNATURE & TITLE (Must be owner, principal officer ot authorized representative)

I certify that I have complied with the requirements of 21 V.S.A. Section 687 relating to securing workers' compensation coverage for my employees and the information contained in this report and all attachments is correct to the best of my knowledge.