

State of Rhode Island

PLEASE CHECK IF CORRECTION OF PRIOR REPORT

EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY OR DISEASE

Department of Labor and Training, Division of Workers' Compensation

DWC No.

PO Box 20190, Cranston, RI 02920-0942

Phone (401) 462-8100 TDD (401) 462-8084 FAX (401) 462-8105

Insurer File No.

1. EMPLOYER LOCATION: FEIN, Name, Address, City, State, Zip, Phone, Ext., Type of Business, RI Unemployment Ins. No., NAICS
2. EMPLOYER NAMED ON WC INSURANCE POLICY: SAME AS BLOCK 1 FEIN, Name, Address, City, State, Zip, Phone, Ext., WC Policy Number

3. INSURANCE COMPANY NAMED ON WC POLICY: FEIN, Name, Address, City, State, Zip, Phone, Ext.
4. CLAIM ADMINISTRATOR: SAME AS BLOCK 3 FEIN, Name, Address, City, State, Zip, Phone, Ext.

5. EMPLOYEE INFORMATION: SSN, Name, Address, City, State, Zip, Phone, Date of Birth, Occupation, Date Hired, State of Hire, Preferred Language of Employee
6. MEDICAL INFORMATION: Treatment Facility, Address, City, State, Zip, Phone, Ext.
7. WITNESS INFORMATION: Name, Phone

8. INJURY INFORMATION: Injury Date, Time injury occurred, Time employee began work, 1. First full day lost from work, 2. Date returned to work, 3. Date employer notified of injury, If fatal - REPORT WITHIN 48 HOURS - Date of death, What was person doing when injured?, List injured body parts and nature of injury

Place where injury/illness occurred: At employer location listed in Block 1 OR Complete address where accident occurred:

Was this injury previously an incident-only with no medical treatment and no time lost? Yes No

If Yes, date employer first notified of medical treatment or time lost

Category(ies) of injury or illness: Injury Illness Occupational Disease Repetitive Trauma Occupational Hearing Loss Unknown

Print Name of Report Preparer Date Prepared Phone & Extension

Print Name of Employer Contact Person OR Same as above Phone & Extension

Table with 8 columns: County, Time A, Time W, OCC, Nature, Part, Source, Type