**State of Rhode Island**

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

**EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY, DISEASE OR FATALITY**

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942
Phone (401) 462-8100 TDD (401) 462-8006 FAX (401) 462-8105

DWC No. _____

Insurer File No.

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

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

| **5. EMPLOYEE INFORMATION:** | | **6. MEDICAL INFORMATION:** |
|---|---|---|
| SSN ☐ Male ☐ Female | | Treatment Facility |
| Name | | Address |
| Address | | City, State, Zip |
| City, State, Zip | | Phone Ext. |
| Phone | Date of Birth | **7. WITNESS INFORMATION:** |
| Occupation | Date Hired | Name Phone |
| State of Hire | Preferred Language of Employee: O English O Spanish O Portuguese O Other: | |

| **8. INJURY INFORMATION:** | What was person doing when injured? |
|---|---|
| Injury Date | |
| Time injury occurred ☐ AM ☐ PM | |
| Time employee began work ☐ AM ☐ PM | |
| 1. First full day lost from work ☐ NONE LOST | |
| 2. Date returned to work (if appropriate) | List injured body parts and nature of injury:(ex: Broken left finger, lower back strain) |
| 3. Date employer notified of injury | |
| If fatal - **REPORT WITHIN 48 HOURS** - Date of death | |
| 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: O Injury O Illness O Occupational Disease O Repetitive Trauma O Occupational Hearing Loss O Unknown | |

| **Print** Name of Report Preparer | Date Prepared | Phone & Extension |
|---|---|---|
| | | |
| **Print** Name of Employer Contact Person OR ☐ Same as above | | Phone & Extension |
| | | |

| DWC: | County | Time A | Time W | OCC | Nature | Part | Source | Type | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |



*For instructions visit our web site: www.dlt.ri.gov/wc*