

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. _____

Payroll Acct. # 5570-10000

Budget Code _____

1. EMPLOYER LOCATION: FEIN Name of Department Community College of Rhode Island Address 400 East Avenue City, State, Zip Warwick, R.I. 02886 Phone/Ext. 825-2311 Type of Business Government RI Unemp.Ins. No. 0557010000 NAICS 611210	2. EMPLOYER NAMED ON WC INSURANCE POLICY: <input type="checkbox"/> SAME AS BLOCK 1 FEIN Name STATE OF RHODE ISLAND Address City, State, Zip Phone/Ext. WC Policy Number
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3. INSURANCE COMPANY NAMED ON WC POLICY: FEIN Name STATE OF RHODE ISLAND Address Address City, State, Zip Phone/Ext.	4. CLAIM ADMINISTRATOR: <input type="checkbox"/> SAME AS BLOCK 3 FEIN 05-6000522 Name Department of Administration Address State Employees' Workers' Compensation Address One Capitol Hill City, State, Zip Providence, RI 02908-5866 Phone/Ext. 401-222-6570
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5. EMPLOYEE INFORMATION: SSN <input type="checkbox"/> Male <input type="checkbox"/> Female Name Home Address City, State, Zip Phone Date of Birth Occupation Date Hired State of Hire Rhode Island Preferred Language of Employee: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Portuguese <input type="checkbox"/> Other:	6. MEDICAL INFORMATION Treatment Facility Address City, State, Zip Phone/Ext.
7. WITNESS INFORMATION: Name & Phone	

8. INJURY INFORMATION: Injury Date Time injury occurred <input type="checkbox"/> AM <input type="checkbox"/> PM Time employee began work <input type="checkbox"/> AM <input type="checkbox"/> PM 1. First full day lost from work <input type="checkbox"/> NONE LOST 2. Date returned to work (if appropriate) 3. Date employer notified of injury (supervisor) If fatal - REPORT WITHIN 48 HOURS- Date of death	What was person doing when injured? List injured body parts and nature of injury:(ex: Broken left finger, lower back strain)
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Place where injury/illness occurred: At employer location listed in Block 1OR 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 <input type="checkbox"/> Same as above		Phone & Extension

DWC:	County	Time A	Time W	OCC	Nature	Part	Source	Type
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INCIDENT/INJURY REPORT FORM

REPORT ALL INJURIES WITHIN 24 HOURS

PLEASE TYPE OR PRINT IN BLACK INK. BE SURE TO PROVIDE ALL REQUESTED INFORMATION

I. EMPLOYEE REPORT

DEPARTMENT/EMPLOYER: _____

LAST NAME: _____ MIDDLE INITIAL: _____ FIRST NAME: _____

ADDRESS: Street, #: _____ City: _____ State: _____ Zip: _____

HOME PHONE: _____ SOC SEC #: _____ SEX: M F AGE: _____

JOB TITLE: _____ DATE OF INCIDENT: _____ TIME OF INCIDENT: _____ AM/PM

BUILDING AND/OR AREA NORMALLY ASSIGNED: _____

BUILDING AND/OR AREA WHERE INCIDENT OCCURRED: _____

HOW MANY HOURS HAD YOU BEEN WORKING IN A ROW WHEN THIS OCCURRED? _____

DO YOU HAVE SUPPLEMENTAL EMPLOYMENT? Y N

WHAT ARE YOUR NORMAL WORK HOURS? _____ AM/PM TO _____ AM/PM

DESCRIBE AND ILLUSTRATE (AT LEFT) YOUR INJURY: _____

DESCRIBE THE INCIDENT: _____

DESCRIBE THE INCIDENT: _____

DESCRIBE THE INCIDENT: _____

DESCRIBE THE INCIDENT: _____

DESCRIBE THE INCIDENT: _____

WAS INJURY/INCIDENT REPORTED TO SUPERVISOR? YES NO

WAS INJURY/INCIDENT WITNESSED BY ANYONE? YES NO

WITNESS NAME (PRINT): _____

EMPLOYEE SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

II. SUPERVISOR REPORT

DATA AND TIME NOTIFIED _____

WAS THERE A SPECIFIC INCIDENT/ACCIDENT? Y N UNKNOWN: DID YOU WITNESS THE INCIDENT/ACCIDENT? Y N

GIVE A STEP BY STEP DESCRIPTION OF WHAT YOU UNDERSTAND TO HAVE HAPPENED:

DRAFT

WAS EMPLOYEE SENT TO DESIGNATED HEALTH CARE FACILITY FOR EVALUATION Yes NO

1. BODILY MOTION 2. INMATE/PRISONER HANDLING 3. OBJECT HANDLING 4. CONTACT

5. SLIP/FALL 6. EXPOSURE/INHALATION 7. INMATE/PRISONER ASSAULT 8. CAUGHT

9. COLLISION/UPSET 10. AGGRAVATION OF PRE-EXISTING CONDITION 11. MISCELLANEOUS

SUPERVISOR NAME (PRINT): _____ SIGNATURE: _____ DATE: _____

ADMINISTRATOR'S SIGNATURE: _____ DATE: _____