

**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

DWC No. \_\_\_\_\_

PO Box 20190, Cranston, RI 02920-0942

Phone (401) 462-8100 TDD (401) 462-8006 FAX (401) 462-8105

Insurer File No. \_\_\_\_\_

<b>1. EMPLOYER LOCATION:</b>		<b>2. EMPLOYER NAMED ON WC INSURANCE POLICY:</b> <input type="checkbox"/> SAME AS BLOCK 1	
FEIN		FEIN	
Name		Name	
Address		Address	
City, State, Zip		City, State, Zip	
Phone	Ext.	Type of Business	Phone
RI Unemployment Ins. No.		NAICS	WC Policy Number
<b>3. INSURANCE COMPANY NAMED ON WC POLICY:</b>		<b>4. CLAIM ADMINISTRATOR:</b> <input type="checkbox"/> SAME AS BLOCK 3	
FEIN		FEIN	
Name		Name	
Address		Address	
Address		Address	
City, State, Zip		City, State, Zip	
Phone	Ext.	Phone	Ext.
<b>5. EMPLOYEE INFORMATION:</b>		<b>6. MEDICAL INFORMATION:</b>	
SSN	<input type="checkbox"/> Male <input type="checkbox"/> Female	Treatment Facility	
Name		Address	
Address		City, State, Zip	
City, State, Zip		Phone	Ext.
Phone	Date of Birth	<b>7. WITNESS INFORMATION:</b>	
Occupation	Date Hired	Name	Phone
State of Hire	Preferred Language of Employee: <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Portuguese <input type="radio"/> Other:		
<b>8. INJURY INFORMATION:</b>		What was person doing when injured?	
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)		List injured body parts and nature of injury:(ex: Broken left finger, lower back strain)	
3. Date employer notified of injury			
If fatal - <b>REPORT WITHIN 48 HOURS</b> - Date of death			
Place where injury/illness occurred: <input type="checkbox"/> At employer location listed in Block 1 <b>OR</b>		Complete address where accident occurred:	
Was this injury previously an incident-only with no medical treatment and no time lost? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, date employer first notified of medical treatment or time lost			
Category(ies) of injury or illness: <input type="radio"/> Injury <input type="radio"/> Illness <input type="radio"/> Occupational Disease <input type="radio"/> Repetitive Trauma <input type="radio"/> Occupational Hearing Loss <input type="radio"/> 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	

<b>DWC:</b>	County	Time A	Time W	OCC	Nature	Part	Source	Type	
-------------	--------	--------	--------	-----	--------	------	--------	------	--

DWC-01 (01/03)

For instructions visit our web site: [www.dlt.ri.gov/wc](http://www.dlt.ri.gov/wc)