

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
 PO Box 20190, Cranston, RI 02920-0942
 Phone (401) 462-8100 TDD (401) 462-8084 FAX (401) 462-8105

DWC No. _____

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: <input type="checkbox"/> SAME AS BLOCK 1 FEIN Name Address City State Zip Phone Ext. WC Policy Number
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3. INSURANCE COMPANY NAMED ON WC POLICY: FEIN Name Address Address City State Zip Phone Ext.	4. CLAIM ADMINISTRATOR: <input type="checkbox"/> SAME AS BLOCK 3 FEIN Name Address Address City State Zip Phone Ext.
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5. EMPLOYEE INFORMATION: SSN <input type="checkbox"/> Male <input type="checkbox"/> Female First Name Last Address City State Zip Phone Date of Birth Occupation Date Hired State of Hire 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 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) Complete address where accident occurred:
Place where injury/illness occurred: <input type="checkbox"/> At employer location listed in Block 1 OR	
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="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Occupational Disease <input type="checkbox"/> Repetitive Trauma <input type="checkbox"/> Occupational Hearing Loss <input type="checkbox"/> 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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DWC-01 (01/03)

For instructions visit our web site:

www.dlt.state.ri.us/wc