

**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. \_\_\_\_\_

<b>1. EMPLOYER LOCATION:</b> FEIN Name Address City State Zip Phone Ext. Type of Business RI Unemployment Ins. No. NAICS	<b>2. EMPLOYER NAMED ON WC INSURANCE POLICY:</b> <input type="checkbox"/> SAME AS BLOCK 1 FEIN Name Address City State Zip Phone Ext. WC Policy Number
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<b>3. INSURANCE COMPANY NAMED ON WC POLICY:</b> FEIN Name Address Address City State Zip Phone Ext.	<b>4. CLAIM ADMINISTRATOR:</b> <input type="checkbox"/> SAME AS BLOCK 3 FEIN Name Address Address City State Zip Phone Ext.
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<b>5. EMPLOYEE INFORMATION:</b> 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:	<b>6. MEDICAL INFORMATION:</b> Treatment Facility Address City State Zip Phone Ext.
<b>7. WITNESS INFORMATION:</b> Name Phone	

<b>8. INJURY INFORMATION:</b> 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 - <b>REPORT WITHIN 48 HOURS</b> - 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 <b>OR</b>	
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](http://www.dlt.state.ri.us/wc)