Department of Labor and Training, Division of Workers' Compensation DWC No.	State of Rhode Island EMPLOYER'S FIRST REPORT O	F ALLEGED OCC	CUPATIONAL INJ	_	HECK IF CORRE	CTION OF PRIO	R REPORT	
FEIN Name	PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8084 FAX (401) 462-8105			Insurer File No.				
Name Address City, State, Zip Phone Ext. Type of Business RI Unemployment Ins. No. NAICS WC Politry Number S. INSURANCE COMPANY NAMED ON WC POLICY: FEIN Name Address City, State, Zip Phone Ext. Ext. Ext. Ext. Ext. Ext. Ext. Ext.	1. EMPLOYER LOCATION:			2. EMPLOYER NAM		NCE POLICY:	SAME AS BLOCK 1	
Address City, State, Zip Phone	FEIN			FEIN				
City, State, Zip Phone Ext. Type of Business Phone Phone Ext. RI Unamployment Ins. No. NAVCS WC Policy Number SAME AS BLOCK3 FEIN Name Address Address Address Address Address City, State, Zip Phone Ext. Phone Ext. SEMPLOYEE INFORMATION: SSN Male Female Address City, State, Zip Phone Ext. Phone Ext. 6. MEDICAL INFORMATION: Treatment Facility Address Address Address Address Address Address Address Address RADDRESS INFORMATION: Treatment Facility Name Address City, State, Zip Phone Date of Birth Phone Ext. 7. WITHESS INFORMATION: Name Preferred Language of Employee: O English O Spanish O Portuguese O Other: 8. INJURY INFORMATION: Time iginy occurred Time iginy occurred Time iginy occurred Time ignory cocurred	Name			Name				
Phone	Address			Address				
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Name Address Address Address City, State, Zip Phone Ext Phone Ext Phone S.EMPLOYEE INFORMATION: SSN Male Address Address Address SN Address Ad	3. INSURANCE COMPANY NAMED ON	4. CLAIM ADMINISTRATOR: SAME AS BLOCK 3						
Address Address Address City, State, Zip Phone Ext. Phone Ext. Phone Ext. Phone Ext. Phone Ext. Phone Ext. Address S. MEDICAL INFORMATION: SSN Male Address City, State, Zip Female Treatment Facility Address City, State, Zip Phone City, State, Zip Phone Date of Birth Cocupation Date of Birth Docupation Date Hired Name Phone Date of Birth Preferred Language of Employee: O English O Spanish O Portuguese O Other: 8. INJURY INFORMATION: Injury Date Time injury occurred Time injury occurred Time injury occurred Injury Date Time employee began work Injury Date Time employee began work Injury Date Time employee house of death Cocupation Date returned to work (if appropriate) 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 If Yes, date employer first notified of medical treatment or time lost Category(ies) of injury or illness O Injury O Illness O Repetitive Trauma O Occupational Hearing Loss O Unknown Print Name of Report Preparer Date Prepared Phone & Ext. Address City, State, Zip Meditores S. MEDICAL INFORMATION: Treatment Facility Address City, State, Zip Phone S. MEDICAL INFORMATION: The different Facility Address City, State, Zip Phone S. MEDICAL INFORMATION: The different Facility Address City, State, Zip Phone S. MEDICAL INFORMATION: The different Facility Address City, State, Zip Phone S. MEDICAL INFORMATION: The different Facility Address City, State, Zip Phone S. MEDICAL INFORMATION: The different Facility Address City, State, Zip Phone S. MEDICAL INFORMATION: The different Facility Address City, State, Zip Phone S. MEDICAL INFORMATION: The different Facility Address City, State, Zip Phone S. MEDICAL INFORMATION: The different Facility Address City, State, Zip Phone S. MEDICAL INFORMATION: The different Facility Address City, State, Zip Phone S. MEDICAL INFORMATION: The different Facility Address City, State, Zip What was person doing when injured? What was person doi	FEIN	FEIN						
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Phone	Address	Address						
S. EMPLOYEE INFORMATION: SSN	City, State, Zip	City, State, Zip						
SSN Male Female Treatment Facility Address Address City, State, Zip Phone Ext.	Phone	Phone Ext.						
Address City, State, Zip Phone	5. EMPLOYEE INFORMATION:	6. MEDICAL INFORMATION:						
Address City, State, Zip Phone Date of Birth Occupation Date Hired Name Phone State of Hire Preferred Language of Employee: O English O Spanish O Portuguese O Other: 8. INJURY INFORMATION: Injury Date Time injury occurred Ime injury occurred Ime employee began work 1. First full day lost from work 1. First full day lost from work 1. Date returned to work (if appropriate) 3. Date employer notified of injury If fatal - REPORT WITHIN 48 HOURS - Date of death Place where injury/illness occurred: Was this injury previously an incident-only with no medical treatment and no time lost? Category(les) of injury or illness: O Injury O Illness O Occupational Disease O Repetitive Trauma O Occupational Hearing Loss O Unknown Print Name of Employer Contact Person OR Same as above O The Page of Trauma O Phone & Extension Print Name of Employer Contact Person OR Same as above O Templete address where accident occurred: Date Prepared Phone & Extension	SSN Male Female			Treatment Facility				
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State of Hire	Phone	Date of Birth		7. WITNESS INFOR	MATION:			
8. INJURY INFORMATION: Injury Date Impury Date Impury occurred	Occupation	Date Hired		Name Phone				
Injury Date Time injury occurred	State of Hire	Preferred Language	of Employee: O Eng	ish O Spanish O Portuguese O Other:				
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Print Name of Employer Contact Person OR Same as above Phone & Extension	Category(ies) of injury or illness: O Inju	e O Repetitive Tra	auma O Occupation	onal Hearing Loss	O Unknown			
	Print Name of Report Preparer	Date Prepared		Phone & Extension				
County Time A Time W OCC Nature Part Source Type	Print Name of Employer Contact Person OR Same as above Phone & Extension							
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