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.

1. EMPLOYER LOCATION:	**2. EMPLOYER NAMED ON WC INSURANCE POLICY:** ☐ **SAME AS BLOCK 1**
FEIN	FEIN
Name	Name
Address	Address
City, State, Zip	City, State, Zip
Phone Ext. Type of Business	Phone Ext.
RI Unemployment Ins. No. NAICS	WC Policy Number

3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ **SAME AS BLOCK 3**
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.

5. EMPLOYEE INFORMATION:		**6. MEDICAL INFORMATION:**
SSN ☐Male ☐Female		Treatment Facility
Name		Address
Address		City, State, Zip
City, State, Zip		Phone Ext.
Phone	Date of Birth	**7. WITNESS INFORMATION:**
Occupation	Date Hired	Name Phone
State of Hire	Preferred Language of Employee: ◯English ◯Spanish ◯Portuguese ◯Other:	

8. INJURY INFORMATION:	What was person doing when injured?
Injury Date	
Time injury occurred ☐AM ☐PM	
Time employee began work ☐AM ☐PM	
1. First full day lost from work ☐ 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 - **REPORT WITHIN 48 HOURS** - Date of death	

Place where injury/illness occurred: ☐ At employer location listed in Block 1 **OR** 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 ☐Same as above		Phone & Extension

DWC:	County	Time A	Time W	OCC	Nature	Part	Source	Type	

For instructions visit our web site: www.dlt.ri.gov/wc

EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY OR DISEASE (DWC-01)

By law, the employer must complete a First Report of Injury for an employee for any work-related injury, if that injury requires any medical treatment or if the employee loses full wages for at least three (3) days.
The employer must also report any work-related death.

General Instructions:

- Clearly print or type information into all of the areas of the First Report. INCOMPLETE FORMS MAY BE REJECTED.
- The First Report Form is to be completed by the employer.
- The First Report must be filed with Department of Labor and Training (DLT) within 10 days of knowledge of the injury OR within 48 hours of death. If you do not send in the First Report on time or if it is incomplete, you may be subject to a $250 fine.
- Submit the original to Department of Labor and Training to the address on the form. Submit a copy to the Claim Administrator. The employer should keep a copy.
- DO NOT ATTACH MEDICAL REPORTS to the DLT form.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check this box if you are sending in an amended form.

1. Employer Location:
- *FEIN:* Employer's Federal Employer Identification Number.
- *Name:* The name of the business by which the employee was employed at the time of the injury.
- *Address (including city, state, zip):* Employer's mailing address.
- *Phone/Ext:* Phone number of the employer's facility. Include an extension if appropriate.
- *Type of Business:* Briefly describe the employer's purpose. (Ex. Restaurant; Jewelry Manufacturing; etc.)
- *RI Unemployment Ins. No.:* This number (ERN – Employer Record Number) is assigned to employers by the Rhode Island Division of Taxation. Employers use this number on the Quarterly Tax and Wage Report form TX-17 for RI Unemployment Insurance and Temporary Disability Insurance taxes. The Division of Worker's Compensation will use this number for employer identification purposes only.
- *NAICS:* North American Industry Classification System, established by the US Census Bureau to provide common industry classifications based on the type of business. Visit www.census.gov and click on NAICS to locate the industry code. If this code is not available, be sure to complete 'Type of business' on the form.

2. Employer Named on WC Insurance Policy: If this information is the same as the information in Block 1, check the 'Same' box, complete the WC Policy Number, and move onto Block 3. If different, proceed below.
- *FEIN:* Federal Employer Identification Number of the employer listed on the WC Insurance Policy.
- *Name:* Insured named on the policy or the financially responsible self-insured employer, as certified by DLT.
- *Address (including city, state, zip):* Mailing address of the employer named on the WC Insurance Policy.
- *Phone/Ext:* Phone number of the named employer's facility. Include extension if appropriate.
- *WC Policy Number:* Number assigned to the WC contract or policy for that employer.

3. Insurance company named on WC Policy:
- *FEIN:* WC insurance company's Federal Employer Identification Number.
- *Name:* Name of the licensed worker's compensation insurance carrier listed on the insurance policy, not the insurance agent or insurance group. List 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Address (including city, state, zip):* Mailing address of the WC insurance carrier named on the WC Insurance Policy.
- *Phone/Ext:* Phone number of the named WC insurance carrier. Include extension if appropriate.

4. Claim Administrator: Identify the entity who will handle the claim, the insurer or a third party administrator. If this information is the same as the insurer information in Block 3, check the 'Same' box, and move to Block 5. If different, proceed below.
- *FEIN:* Federal Employer Identification Number of the company administering the claim.
- *Name:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Address (including city, state, zip):* Mailing address of the claim administrator.
- *Phone/Ext:* Phone number of the claim administrator. Include extension if appropriate.

5. Employee:

- *SSN:* Employee's Social Security Number.
- *Male/Female:* Check one.
- *Name:* Employee's full name as shown on social security card.
- *Address (including city, state, zip):* Employee's current mailing address.
- *Phone:* Employee's current home telephone number.
- *Date of Birth:* Date the employee was born.
- *Occupation:* Primary occupation of the employee at the time of the accident.
- *Date Hired:* Date the employee began his or her employment with the employer.
- *State of Hire:* State in which the employee was actually hired.
- *Preferred Language of Employee:* Primary language spoken or understood by the employee.

6. Medical Information:

- *Treatment Facility:* Name of the facility where employee received treatment for injury or illness.
- *Address (including city, state, zip):* Treatment facility address.
- *Phone/Ext:* Phone number of the treatment facility. Include extension if appropriate.

7. Witness Information:

- *Name:* Name of person or persons who witnessed injury.
- *Phone:* Phone number(s) of witness(es)

8. Injury Information:

- *Injury Date:* Date that the accident happened.
- *Time injury occurred:* Time that the injury happened.
- *Time employee began work:* Time that the employee began work on the day the injury happened.
- *First full day lost from work:* First full day that the employee lost from work (include scheduled days off, weekends and holidays). This is referred to as the Incapacity Date throughout the claim. Check *NONE LOST* if the employee lost no time due to the injury.
- *Date returned to work (if appropriate):* If employee has returned to work, enter the date.
- *Date employer notified of injury:* Date that the injury was reported to a representative of the employer.
- *If fatal, REPORT WITHIN 48 HOURS – Date of Death:* If employee died, enter the date of death.
- *What was person doing when injured?:* Describe how the accident happened. List any objects that caused the injury.
- *List injured body parts and nature of injury:* Description of what body part or parts were injured and what type of injury it is. (EX. Heat burn to right index finger and right middle finger, fractured left ankle)
- *Place where injury/illness occurred:* Check this box if the injury happened at the address of the employer listed in Block 1 OR enter the complete address (including city and state) where injury actually took place.
- *Was this injury previously an incident-only with no medical treatment and no time lost?* Check *No* if that is the appropriate answer. Checking *Yes* refers to injuries which were originally not reportable to the State—meaning that the employee lost no time or received no medical treatment for the injury (incident only). If the injury later becomes reportable because the employee now has lost full wages for at least three (3) days or received any medical treatment due to the work-related injury, then check *Yes*.
- *If Yes, date employer first notified of medical treatment or time lost:* If *Yes* was checked on the previous question, enter appropriate date.
- *Category(ies) of injury or illness:* Check the appropriate item(s).
- *Print Name of Report Preparer/Date Prepared/Phone & Extension:* Clearly enter the name of the person who filled out the form, the date that the form was prepared, and the complete phone number of the preparer.
- *Print Name of Employer Contact Person OR Same as above /Phone & Extension:* Clearly enter the name and complete phone number of the employer contact person OR check the SAME box if the employer contact person also prepared the report.