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:			**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	

DWC-01 (01/03) *For instructions visit our web site: www.dlt.state.ri.us/wc*