### Employer's First Report of Alleged Occupational Injury, Disease or Fatality

**State of Rhode Island**
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**

#### 1. Employer Location:

<table>
<thead>
<tr>
<th>FEIN</th>
<th>Name</th>
<th>Address</th>
<th>City, State, Zip</th>
<th>Phone</th>
<th>Ext.</th>
<th>Type of Business</th>
</tr>
</thead>
</table>

#### 2. Employer Named on WC Insurance Policy:

- **SAME AS BLOCK 1**

<table>
<thead>
<tr>
<th>FEIN</th>
<th>Name</th>
<th>Address</th>
<th>City, State, Zip</th>
<th>Phone</th>
<th>Ext.</th>
</tr>
</thead>
</table>

#### 3. Insurance Company Named on WC Policy:

- **SAME AS BLOCK 3**

<table>
<thead>
<tr>
<th>FEIN</th>
<th>Name</th>
<th>Address</th>
<th>City, State, Zip</th>
<th>Phone</th>
<th>Ext.</th>
<th>Type of Business</th>
</tr>
</thead>
</table>

#### 4. Claim Administrator:

- **SAME AS BLOCK 3**

<table>
<thead>
<tr>
<th>FEIN</th>
<th>Name</th>
<th>Address</th>
<th>City, State, Zip</th>
<th>Phone</th>
<th>Ext.</th>
</tr>
</thead>
</table>

#### 5. Employee Information:

<table>
<thead>
<tr>
<th>SSN</th>
<th>Male</th>
<th>FEIN</th>
<th>Name</th>
<th>Address</th>
<th>City, State, Zip</th>
<th>Phone</th>
<th>Ext.</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

#### 6. Medical Information:

- **Treatment Facility**

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City, State, Zip</th>
<th>Phone</th>
<th>Ext.</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

#### 7. Witness Information:

| Occupation | Date Hired | Name | Phone | State of Hire | Preferred Language of Employee: | |
|------------|------------|------|-------|---------------|---------------------------------|

#### 8. Injury Information:

<table>
<thead>
<tr>
<th>Injury Date</th>
<th>Time injury occurred</th>
<th>Time employee began work</th>
<th>What was person doing when injured?</th>
</tr>
</thead>
</table>

- **List injured body parts and nature of injury:**
  - Broken left finger, lower back strain

<table>
<thead>
<tr>
<th>Category(ies) of Injury or Illness:</th>
<th>Injury</th>
<th>Illness</th>
<th>Occupational Disease</th>
<th>Repetitive Trauma</th>
<th>Occupational Hearing Loss</th>
<th>Unknown</th>
</tr>
</thead>
</table>

- **Print Name of Report Preparer**

<table>
<thead>
<tr>
<th>Print Name of Employer Contact Person OR</th>
<th>Date Prepared</th>
<th>Phone &amp; Extension</th>
</tr>
</thead>
</table>

**For instructions visit our web site:** [www.dlt.ri.gov/wc](http://www.dlt.ri.gov/wc)