

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

DWC No. _____

PO Box 20190, Cranston, RI 02920-0942

Phone (401) 462-8100 TDD (401) 462-8006 FAX (401) 462-8105

Insurer File No. _____

1. EMPLOYER LOCATION: FEIN Name Rhode Island School of Design Address 2 College Street City, State, Zip Providence, RI 02903 Phone (401) 454-6428 Ext. _____ Type of Business Education RI Unemployment Ins. No. 00719927 NAICS _____	2. EMPLOYER NAMED ON WC INSURANCE POLICY: <input type="checkbox"/> SAME AS BLOCK 1 FEIN Name Rhode Island School of Design Address 2 College Street City, State, Zip Providence, RI 02903 Phone (401) 454-6428 Ext. _____ WC Policy Number 3102812534
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3. INSURANCE COMPANY NAMED ON WC POLICY: FEIN 020515329 Name MEMIC Address 261 Commercial Street Address _____ City, State, Zip Portland , ME 04101 Phone (207) 791-3300 Ext. _____	4. CLAIM ADMINISTRATOR: <input checked="" type="checkbox"/> SAME AS BLOCK 3 FEIN Name Address Address _____ City, State, Zip Phone - Ext. _____
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5. EMPLOYEE INFORMATION: SSN _____ <input type="checkbox"/> Male <input type="checkbox"/> Female Name Address City, State, Zip Phone _____ Date of Birth _____ Occupation _____ Date Hired _____ State of Hire _____ Preferred Language of Employee: <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Portuguese <input type="radio"/> Other:	6. MEDICAL INFORMATION: Treatment Facility Address City, State, Zip Phone _____ Ext. _____
7. WITNESS INFORMATION: Name _____ Phone _____	

8. INJURY INFORMATION: 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 - REPORT WITHIN 48 HOURS - Date of death	What was person doing when injured? List injured body parts and nature of injury:(ex: Broken left finger, lower back strain)
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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
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Print Name of Employer Contact Person OR <input type="checkbox"/> Same as above	Phone & Extension
Melanie Gomes, Benefit Partner	(401) 454-6428

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