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 Rhode Island School of Design	Name Rhode Island School of Design
Address 2 College Street	Address 2 College Street
City, State, Zip Providence, RI 02903	City, State, Zip Providence, RI 02903
Phone (401) 454-6428 Ext. Type of Business Education	Phone (401) 454-6428 Ext.
RI Unemployment Ins. No. 00719927 NAICS	WC Policy Number 3102812534

3. INSURANCE COMPANY NAMED ON WC POLICY:	4. CLAIM ADMINISTRATOR: ✔ SAME AS BLOCK 3
FEIN 020515329	FEIN
Name MEMIC	Name
Address 261 Commericial Street	Address
Address	Address
City, State, Zip Portland , ME 04101	City, State, Zip
Phone (207) 791-3300 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: O English O Spanish O Portuguese O 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: O Injury O Illness O Occupational Disease O Repetitive Trauma O Occupational Hearing Loss O Unknown

Print Name of Report Preparer	Date Prepared	Phone & Extension

Print Name of Employer Contact Person OR ☐ Same as above	Phone & Extension
Melanie Gomes, Benefit Partner	(401) 454-6428

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

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