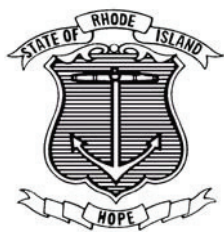


STATE OF RHODE ISLAND  
DEPARTMENT OF LABOR & TRAINING



This employer is subject to the provisions of the  
**WORKERS' COMPENSATION ACT**  
of the State of Rhode Island

Workers' Compensation Insurance Company: \_\_\_\_\_  
Adjusting Company: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_

In accordance with Rhode Island General Law §28-32-1, the **employer must report** to the Director of Labor and Training **every personal injury sustained by an employee if the injury incapacitates the employee from earning full wages for at least three (3) days or requires medical treatment, regardless of the period of incapacity.** If the injury proves fatal, the report must be filed within forty-eight (48) hours. If not fatal, the report shall be made within ten (10) days of the injury.

**An injured employee shall have the freedom to choose medical treatment initially.** The employee's first visit to any facility under contract or agreement with the employer or insurer to provide priority care **shall not be considered** the employee's initial choice.

For more information about Workers' Compensation procedures and benefits, call the Education Unit at (401) 462-8100 and press option #1 or TDD (401) 462-8006. If you suspect fraud, contact the Fraud Prevention Unit at (401) 462-8100 and press option #7.

In accordance with Rhode Island General Law §28-29-13, this notice must be posted and maintained in conspicuous places where workers are employed.  
Fines may be imposed for noncompliance.

# DEPARTAMENTO DE TRABAJO Y ENTRENAMIENTO DEL ESTADO DE RHODE ISLAND



Esta empresa esta sujeta a las estipulaciones del

## **ACTA DE COMPENSACION DE TRABAJADORES**

del Estado de Rhode Island

Seguro de Compensación de Trabajo \_\_\_\_\_

Compañía Ajustadora: \_\_\_\_\_

Teléfono: \_\_\_\_\_

Fecha Efectiva de Póliza: \_\_\_\_\_

De acuerdo con las Leyes Generales de Rhode Island §28-32-1, **las empresas tienen que reportarle al Director de Trabajo y Entrenamiento cada lesión personal reportada por un empleado si la lesión incapacita al empleado de ganar un sueldo completo por un mínimo de tres (3) días, o requiere tratamiento médico, sin importar el período de incapacidad.** Si la lesión es fatal, el incidente debe ser reportado dentro de cuarenta y ocho (48) horas. Si no es fatal, el incidente será reportado dentro de diez (10) días de la lesión.

**Un empleado lesionado tiene la libertad de escoger al primer proveedor médico.** La primera visita del empleado a cualquier centro de atención médico contratado por la empresa o la aseguradora, con la intención de facilitar atención inmediata, **no será considerado** el primer proveedor médico.

Para más información referente a la compensación para trabajadores a causa de accidentes de trabajo, procedimientos y beneficios, llame a la Unidad Educacional al (401) 462-8100 y apriete la opción #1 o TDD (401) 462-8006. Si usted sospecha de fraude, póngase en contacto con la Unidad de Prevención de Fraude al (401) 462-8100 y apriete la opción #7.

De acuerdo con las Leyes Generales de Rhode Island §28-29-13, este aviso debe ser colocado y mantenido en lugares visibles para los trabajadores. Las empresas que no cumplan con este requerimiento pueden ser sujetas a multas.



## 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](http://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.