

First Report of Injury (DWC-01)

An employer must report work-related injuries to his workers' compensation insurer and to The Department of Labor and Training, Division of Workers' Compensation (DWC). Any injury related to employment which is fatal, where the employee loses wages for at least three days, or where the injury requires medical treatment must be reported. The insurer is encouraged to submit the First Report to the DWC on behalf of the employer.

The first report is due within 10 days after the employer has knowledge of the injury. The employer may be subject to a \$250 penalty for failure to report to DWC.

Instructions:

- PLEASE CHECK IF CORRECTION OF PRIOR REPORT: Check this box if this is a new version of the form with updated information.
- DWC no. For DWC use only
- Insurer File number: Provide the claim number or file identification number used by the claim handler (insurer or third party administrator).

1. Employer Location: Provide the employer's information for the location where the employee was working when injured.

- FEIN: Employer's Federal Employer Identification Number.
- Name: The employer's **business name** is required.
- Address, city, state, zip: The employer's business address is required.
- Phone: Phone number for the employer's facility.
- Type of Business: Indicate what the business does on a daily basis. (Ex. Restaurant; Jewelry Manufacturing; etc.)
- RI Unemployment Ins. No.: This is the Employer Record Number (ERN) assigned to employers by the Rhode Island Division of Taxation to identify employers paying RI Unemployment Insurance and Temporary Disability Insurance taxes. It is used here for employer identification purposes only.
- NAICS: A US Census Bureau code to identify the employer's industry classification. Leave blank if not known.

2. Employer Named on WC Insurance Policy: Provide the insured employer named on the policy if it is different from block 1. If same, check "same as block 1", fill in the WC policy number, and leave the rest of this block blank.

- 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, city, state, zip, phone: Provide the mailing address and phone number of the employer named on the WC Insurance Policy.
- WC Policy Number: Number assigned to the WC insurance policy covering this employer. If self-insured, leave policy number blank.

3. Insurance company named on WC Policy: Provide information for the insurance company named on the policy. If the employer is certified by DWC as self-insured, provide the self-insured employer information.

- FEIN: WC insurance company's Federal Employer Identification Number, if available.

- Name: Name of the worker's compensation insurer as listed on the policy. Use the specific licensed insurer's name instead of the general insurer group name. If the employer is self-insured, write in "Self-Insured" or give the self-insured business name.
- Address, city, state, zip, phone: Mailing address and phone number of the WC insurance carrier named on the WC Insurance Policy.

4. Claim Administrator: Indicate the company handling the claim, which may be either the insurer or a third party administrator. If this is the same as the insurer information in block 3, check "Same as block 3" and leave the rest of block 4 blank.

- FEIN: Federal Employer Identification Number of the company handling the claim, if available.
- Name: Business name of company handling this claim.
- Address, city, state, zip, phone: Mailing address and phone number of the claim administrator.

5. Employee: Provide information about the injured worker.

- SSN: Employee's Social Security Number. Provide the full number or the last 4 digits. If the SSN is not available, DO NOT provide a fictitious number.
- Male/Female: Check one. If unknown, leave blank.
- Name: The employee's full name is required.
- Address, city, state, zip: Employee's current mailing address is required.
- Phone: Employee's home or cell 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 hired.
- Preferred Language of Employee: Primary language spoken or understood by the employee.

6. Medical Information: Provide the name, address and phone number of the facility where the employee received medical treatment for the injury.

7. Witness Information: If there was a witness to the injury, please provide the witness name and a phone number where the witness can be reached.

8. Injury Information: Provide information about the injury or illness.

- Injury Date: Date that the accident happened or the worker became ill.
- 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 was unable to work after the injury, INCLUDING unscheduled work days. Check NONE LOST if the employee was able to work after the injury.
- Date returned to work: If employee has returned to work, give the date.
- Date employer notified of injury: Date that the injury was reported to the employer.
- If fatal, REPORT WITHIN 48 HOURS – Date of Death: if the employee died, provide the date of death.
- What was person doing when injured: Briefly describe how the accident happened.

- List injured body parts and nature of injury: Indicate what body parts were injured and the kind of injury to each part. Examples: bruised right elbow, cut left cheek, strained low back.
- Place where injury/illness occurred: Indicate where the injury happened. Check the box if the injury happened at the employer address in block 1. Otherwise, give the address where the injury took place.
- Was this injury previously an incident-only with no medical treatment and no time lost?: If an injury does not initially require medical treatment and lost time is 3 days or less, the injury need not be reported and is referred to as “incident-only”. Later on, if the employee needs medical treatment or loses time, the injury must be reported. In this case, check “YES” and on the next line, provide the date the employer was notified of the medical treatment or lost time.
- Category(ies) of injury or illness: Select the closest category for this illness or injury.

9. Preparer and Contact Person:

- Print Name of Report Preparer/Date Prepared/Phone & Extension: Clearly print the name of the person who filled out the form, the date that the form was prepared, and the phone number of the preparer.
- Print Name of Employer Contact Person OR Same as above /Phone & Extension: Clearly print the name and phone number of the employer’s contact person.