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 20 Washington Place	Address 20 Washington Place
City, State, Zip Providence, RI 02903	City, State, Zip Providence, RI 02903
Phone (401) 454-6429 Ext. Type of Business Education	Phone (401) 454-6429 Ext.
RI Unemployment Ins. No. 00719927 NAICS	WC Policy Number 60782

3. INSURANCE COMPANY NAMED ON WC POLICY:	4. CLAIM ADMINISTRATOR: ☐ SAME AS BLOCK 3
FEIN	FEIN
Name The Beacon Mutual Insurance Co.	Name The Beacon Mutual Insurance Co.
Address One Beacon Center	Address One Beacon Center
Address	Address
City, State, Zip Warwick, RI 02886-1378	City, State, Zip Warwick, RI 02886-1378
Phone (401) 825-2667 Ext.	Phone (401) 825-2667 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
Catherine Davis, Director, Compensation, Benefits & HRIS	(401) 454-6429

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