# Employee Report

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

**EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY, DISEASE, OR FATALITY**

Insurer File No.

| **1. EMPLOYER LOCATION:** | **2. EMPLOYER NAMED ON WC INSURANCE POLICY:** ☐ SAME AS BLOCK 1 |
|---|---|
| FEIN | FEIN |
| Name | Name East Greenwich Public Schools |
| Address | Address 111 Peirce Street |
| City, State, Zip | City, State, Zip East Greenwich, RI 02818 |
| Phone/Ext. Type of Business | Phone/ Ext. (401) 398-1222 |
| | WC Policy Number |

| **3. INSURANCE COMPANY NAMED ON WC POLICY:** | **4. CLAIM ADMINISTRATOR:** ☐ SAME AS BLOCK 3 |
|---|---|
| FEIN | FEIN |
| Name The Trust Risk Management | Name |
| Address 10 Hemingway Drive | Address |
| Address | Address |
| City, State, Zip East Providence, RI 02915 | City, State, Zip |
| Phone/ Ext. (401) 438-6511 | 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: | ☐ English ☐ Spanish ☐ Portuguese ☐ 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: ☐ Injury ☐ Illness ☐ Occupational Disease ☐ Repetitive Trauma ☐ Occupational Hearing Loss ☐ Unknown

| **Print** Name of Report Preparer | Date Prepared | Phone & Extension |
|---|---|---|
| **Print** Name of Employer Contact Person OR ☐ Same as above | | Phone & Extension |

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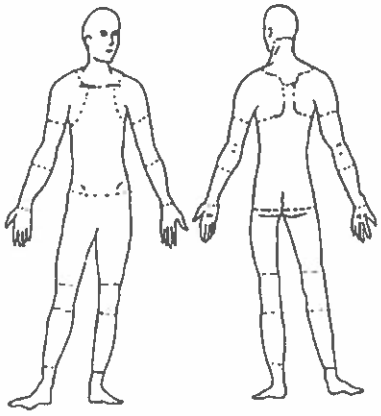
East Greenwich School Department
Fiscal Office
111 Peirce Street
East Greenwich, RI 02818

# Incident Investigation Report

**Instructions**: Complete this form as soon as possible after an incident that results in serious injury or illness. (Optional: Use to investigate a minor injury or near miss that *could have resulted in a serious injury or illness.*)

| | |
|---|---|
| This is a report of a: ❑ Death ❑ Lost Time ❑ Dr. Visit Only ❑ First Aid Only ❑ Near Miss | |
| Date of incident: | This report is made by: ❑ Employee ❑ Supervisor ❑ Team ❑ Other_____ |

## Step 1: Injured employee (complete this part for each injured employee)

| | | |
|---|---|---|
| Name: | Sex: ❑ Male ❑ Female | Age: |
| Department: | Job title at time of incident: | |
| Part of body affected: (shade all that apply)  | Nature of injury: (most serious one)<br>❑ Abrasion, scrapes<br>❑ Amputation<br>❑ Broken bone<br>❑ Bruise<br>❑ Burn (heat)<br>❑ Burn (chemical)<br>❑ Concussion (to the head)<br>❑ Crushing Injury<br>❑ Cut, laceration, puncture<br>❑ Hernia<br>❑ Illness<br>❑ Sprain, strain<br>❑ Damage to a body system:<br>❑ Other _____ | This employee works:<br>❑ Regular full time<br>❑ Regular part time<br>❑ Seasonal<br>❑ Temporary<br>Months with this employer<br>Months doing this job: |

## Step 2: Describe the incident

| | |
|---|---|
| Exact location of the incident: | Exact time: |
| What part of employee's workday? ❑ Entering or leaving work ❑ Doing normal work activities ❑ During meal period ❑ During break ❑ Working overtime ❑ Other_____ | |
| Names of witnesses (if any): | |