



**STATE EMPLOYEES WORKERS' COMPENSATION**  
**One Capitol Hill, Providence, RI 02908**

**24 HOUR NOTIFICATION OF INCIDENT/INJURY**  
**(To be Completed by Supervisor)**

**Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Employee ID #** \_\_\_\_\_

**Agency:** \_\_\_\_\_ **Payroll Account#:** \_\_\_\_\_

**Injury Date:** \_\_\_\_\_ **Incapacity Date:** \_\_\_\_\_

**Time:** \_\_\_\_\_ AM / PM **RTW:** \_\_\_\_\_

**Location of Incident:** \_\_\_\_\_

**Body Part Injured:** \_\_\_\_\_

**Description of Incident:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Date Employer Notified:** \_\_\_\_\_

**Supervisor's Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Employee's Physician:** \_\_\_\_\_ **Witness:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Supervisor:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Fax this form to Human Resources at 874-5530 within 24 hours of incident.**

**Contact Human Resources at 874-9054 if you have any questions.**