STATE EMPLOYEES WORKERS' COMPENSATION

One Capitol Hill
Providence, RI 02908

24 HOUR NOTICE OF INCIDENT/INJURY

To be completed by Supervisor
and faxed to HR at 874-5530

Employee's First and Last Name:	Phone #:
Employee's Occupation/Job Title:	
Agency:	Payroll Account #:
Injury Date:	Incapacity Date:
Time of Injury: : AM or PM	Return to Work Date (***same day as injury if no time lost)***:
No Lost Time:	
Location of Incident:	
Indicate Body Part Injured:	
Description of Incident:	
Date Department Notified:	
Supervisor's Comments:	
Doctor/Clinic/Treatment Center Employee Went To:	
Doctor/Clinic/Treatment Center's Phone #:	
Name of Witness:	Witness's Phone #:
Supervisor's Name *(Please Print)*:	
Supervisor's Signature:	
Supervisor's Office Phone #:	Today's Date:

Fax this form to Leslie Cronan in HR at 874-5530 within 24 hours of an incident.

Contact Leslie at 874-2684 with any questions