



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

24 HOUR NOTIFICATION OF INCIDENT/INJURY
(To be Completed by Supervisor and faxed within 24 hours to HR at 874-5530)

Name: _____ **Occupation:** _____

Phone #: _____ **Employee ID #** _____

Agency: URI _____ **Payroll Account#:** 551010000

Injury Date: _____ **Incapacity Date:** _____

Time: _____ AM / PM **RTW:** _____

Location of Incident: _____

Body Part Injured: _____

Description of Incident: _____

Date Employer Notified: _____

Supervisor's Comments: _____

Supervisor: _____ **Phone #:** _____

Employee's Physician: _____ **Witness:** _____

Phone #: _____ **Phone #:** _____

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

Contact Leslie in HR at 874-2684 with any questions.