



STATE EMPLOYEES WORKERS' COMPENSATION

One Capitol Hill
Providence, RI 02908

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

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 (<i>same day as injury if no time lost</i>):
No Lost Time:		
Location of Incident/Building:		
Indicate Body Part Injured:		
Description of Incident:		
Date Supervisor/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 (<i>Please Print</i>):		
Supervisor's Signature:		
Supervisor's Office Phone #:	Today's Date:	

In order to expedite the processing of a claim it is important that this form be forwarded to your Human Resource Office promptly. Any questions, please call your Human Resource Office or State Employees Workers' Compensation (574-8500).