Employee Accident

The Trust
501 Wampanoag Trail, Suite 301
East Providence, RI 02915
Tel: 401-438-6511
Claims Fax: 401-434-6096
www.ritrust.com

To be completed by employee – PLEASE FILL OUT COMPLETLY

SS#_____

Employee Name:_____ Position:_____

Address:_____ Home Phone:_____

City, State, Zip:_____

Employee #:_____ Date of Hire:_____

Date of Birth:_____ Marital Status:_____ No. of Dependents:_____

Date of Accident:_____ Time:_____ ____AM ____PM

Time Day Began:_____ ____AM ____PM

Date Reported to Supervisor:_____ Time:_____ ____AM ____PM

Building/Facility where accident occurred:_____

Room/Area where accident occurred:_____

Describe fully what you were doing and how accident occurred:_____

_____

_____

List/describe injury/illness_____

Is this a pre-existing condition? _____ Yes _____ No

Have you received or are you receiving Workers' Compensation Insurance? _____Yes _____No

Witness(es)? – If so, name and school phone number_____

Have you been, or do you plan to be, seen by a physician? _____Yes _____No

Name of Treatment Facility, if seen for this injury _____

Address of Treatment Facility, if seen for this injury _____

_____

I attest that the above information has been accurately completed to the best of my knowledge. I also hereby request and authorize disclosure, whenever requested to do so by The Rhode Island Interlocal Risk Management Trust or its' representatives, any and all information which concerns myself with respect to illness or injury, medical history, consultation, prescription or treatment, including X-Ray plates and copies of all hospital records.

NOTE: THIS IS NOT A RELEASE OF ANY CLAIM I MAY HAVE

Employee Signature_____Date_____

Employee Accident

The Trust
501 Wampanoag Trail, Suite 301
East Providence, RI 02915
Tel: 401-438-6511
Claims Fax: 401-434-6096
www.ritrust.com

Employee Name:_____ Date of Injury:_____

To be completed by Supervisor:

When were you notified of the accident/injury: Date: _____ Time: _____ ___ AM ___PM

Was employee paid in full for day of accident? _____ Yes _____No

Did employee return to work that day? _____ Yes _____ No If not, expected date of return _____

What was the next scheduled date for employee to work? _____

Was safety appliance/regulation provided? _____ Yes _____ No Was it in use? _____ Yes _____ No

Was injury a result of a device malfunction? _____ Yes _____ No

Was accident caused by failure to use safety appliance or regulation? _____ Yes _____ No

What is being done to prevent the reoccurrence of this accident?_____
_____
_____
_____

Other comments:_____
_____
_____

I attest that the above information has been accurately completed to the best of my knowledge.

Supervisor Signature_____ Date_____