NOTIFICATION OF CLAIM OF COMPENSABLE INJURY

TO BE SUBMITTED TO INSURER WITHIN THREE (3) DAYS OF INITIAL VISIT WITH A COPY TO THE EMPLOYEE AND HIS OR HER ATTORNEY

DWC/MAB #: _____ ***INSURER'S #:*** _____

EMPLOYEE INFORMATION:

Social security # _____

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____ DOB _____

EMPLOYER INFORMATION:

FEIN # _____

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____

INSURANCE CARRIER:

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____

Injury Date _____

ADJUSTING COMPANY:

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____

IF THE IDENTITY OF THE INSURER IS UNKNOWN, CONTACT THE DIVISION OF WORKERS' COMPENSATION AT (401) 462-8116 FOR THE INFORMATION. SECTION 28-33-8(b) OF THE RHODE ISLAND WORKERS' COMPENSATION ACT PROVIDES FOR A $20.00 FEE TO BE CHARGED FOR THE TIMELY FILING OF THIS FORM.

1. In the patient's own words, relate how the injury happened: _____

_____

2. Patient's complaints (nature and location of injury) : _____

_____

3. Initial diagnosis: _____

4. Description of employee's job: _____

_____

5a. Is the patient released to work, full duty? ☐ Yes ☐ No

If the answer is YES, there is no need to submit a return to work form.

5b. If the answer to 5a is NO, indicate anticipated return to work date:

Modified RTW date: _____ Regular RTW date: _____

6. Date(s) of examination on which this report is based: _____

Are you continuing treatment? ☐ Yes ☐ No

If YES, when will patient be seen again? _____

Physician's Signature_____ Date _____

Physician's Name _____ Treatment Facility _____

Physician's Assistant Signature _____

Supervising Physician's Name _____

Physician's Address _____