Rhode Island Department of Corrections
Initial Injury Report

Please type or print in black ink.
Be sure to provide all requested information.

EMPLOYEE SECTION	☐ Adult Services ☐ Field Services ☐ Management ☐ Policy & Development
Last Name:	**Middle Initial:** **First Name:**
Address, Street:	**City:** **State:** **Zip:**
Home Phone: **Soc. Sec.#**	**Gender: M ☐ F ☐** **Date of Birth:**
Job Title: **Date of Incident:**	**Time of Incident: AM / PM** **Date of Hire:** **Marital Status:**
Building, And/Or Area Normally Assigned:	
Building, And/Or Area Where Incident Occurred:	
How Many Hours Had You Been Working in a Row When This Occurred?	
Do you have Supplemental Employment? Yes ☐ No ☐	**Describe and Illustrate (at left) your injury:**
What are your Normal Work Hours? From: AM / PM To AM / PM	
Indicate on These Figures the Affected Body Part(s) at the Time of the Injury: R L L R	**Describe the Incident / What caused the injury?**
	Was Injury/Incident Reported to Supervisor? Y ☐ N ☐ **Was Injury/Incident Witnessed by Anyone? Y ☐ N ☐**
	Date Supervisor Notified:
	Witness Name (Print):
Employee Signature: **Date:**	**Witness Signature:** **Date:**

SUPERVISOR SECTION			
Was there a specific incident/accident? Y ☐ N ☐ Unknown ☐ Did you witness the incident/accident? Y ☐ N ☐ **Give a step-by-step Description of what you understand to have happened:**			
Was Employee Sent to Designated Health Care Facility for Evaluation? Y ☐ N ☐			
1. ☐ Bodily Motion	**2. ☐ Inmate/Prisoner Handling**	**3. ☐ Object Handling**	**4. ☐ Contact**
5. ☐ Slip/Fall	**6. ☐ Exposure/Inhalation**	**7. ☐ Inmate/Prisoner Handling**	**8. ☐ Caught**
9. ☐ Collision/Upset	**10. ☐ Aggravation of Pre-Existing Condition**	**11. ☐ Miscellaneous**	
Supervisor's Name (Print)	**Signature:**	**Date:**	
Assault Code: A ☐ B ☐ C ☐	**Administrator's Signature:**	**Date:**	