

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 COMPLETELY

SS# _____
Employee Name: _____ Position: _____
Address: _____ Home Phone: _____
City, State, Zip: _____
Date of Hire: _____ Date of Birth: _____
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 – include specific body part i.e. left foot, right arm

Is this a pre-existing condition? _____ 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.

TO BE COMPLETED AND SENT TO HUMAN RESOURCES WITHIN 24 HOURS OF INCIDENT/INJURY

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

Employee Signature _____ Date _____

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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 _____