Initial Injury Report - Instructions

Red Letters in the list below correspond to where the information can be found on the Initial Injury Report. See the corresponding red letters on each of the two form examples:

Page 2: State of Rhode Island - Initial Injury Report Example
Page 3: RI Department of Corrections - Initial Injury Report Example

- Address where the injury occurred
- **A. Has the employee been, or does the employee plan to be, treated for this injury?**
- Has the employee been taken out of work for more than 3 full days (not including injury date)?
- Employee Injury information
  - **B. Body Part/Location**
  - **C. Nature of Injury**
  - **D. Action that caused injury**
  - **D. What was the employee working on or with when the injury occurred?**
  - **D. Description of how the injury occurred**
- Employee Information
  - **E. Social Security Number**
  - **F. Date of Birth**
  - **G. Name**
  - **H. Gender**
  - **I. Marital Status**
  - **J. Address**
  - **K. Phone**
  - **L. Job Title**
  - **M. Date of Injury**
  - Employment Status (Full Time / Part Time)
- Dates Needed:
  - **M. Date of Injury**
  - Date of Death (if a fatality)
  - Last Date Worked
  - Date Employee Started Work with the company
  - **N. Date you were notified of the injury**
  - **O. Date of Hire**

The State of Rhode Island
Beacon Mutual Insurance Company, TPA
One Beacon Centre, Warwick, RI 02886-1378
Main Office: 401.825.2667 (COMP) or Toll Free: 1.888.886.4450
Claims Fax: 401.825.2980 | www.beaconmutual.com

State of Rhode Island
Initial Injury Report – Example

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

EMPLOYEE SECTION	Agency:	Assigned Building:

Last Name: G **First Name:** G **Middle Initial:**

Home Address (Not PO Address) and Phone Number | **Social Security #:** E | **Marital Status:** I

Street: J | **Job Title:** L

City: | **Assigned Shift:** 1st ☐ 2nd ☐ 3rd ☐ Other: ☐

State: | **Zip:** | **Phone:** K | **Shift When Incident Occurred:**

Date of Incident: M | **Time of Incident:** AM / PM | **Date of Hire:** O | **Date of Birth:** F | H **Gender:** M ☐ F ☐

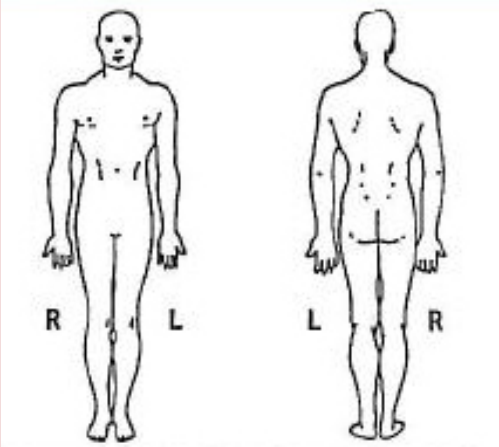
Work Area and Building Where Incident Occurred *(e.g. Kitchen in Regan)*:

How Many Hours *In a Row* Had You Been Working *Just Prior* to this incident?

Do you have Supplemental Employment? Yes ☐ No ☐

What are your Normal Work Hours?
From: AM / PM **To** AM / PM

B Circle the Affected Body Part(s) at the Time of the Injury:



Number of Affected Body Part(s) *in order of relevance*:

a.___ Ankles	f.___ Hands	j.___ Legs
b.___ Arms	g.___ Head/Neck	k.___ Shoulders
c.___ Back	h.___ Hips	l.___ Torso/Groin
d.___ Elbows	i.___ Knees	m.___ Wrists
e.___ Feet		

C Describe *how* the injury occurred *(e.g., lifting patient, etc.)*:

D Describe the nature of your injury *(e.g., bite, sprain, burn, etc.)*:

Did You Report this Incident to Your Supervisor? Y ☐ N ☐
If Yes, Name of Person:

Date Supervisor Notified: N

Did Anyone Witness This Incident? Y ☐ N ☐
If Yes, Name of Witness(s):

Employee's Signature:

Today's Date:

SUPERVISOR SECTION

Provide a Detailed Description of What You Understand to Have Happened *(include date and time of notification):*

A Was Employee Sent to a Clinic/Treatment Center? Y ☐ N ☐ **If Yes, Where?**

Number incident/injury cause(s) *in order of relevance*:

1.___ Bodily Motion	4.___ Contact	7.___ Patient/Inmate Assault	10.___ Miscellaneous
2.___ Patient/Inmate Handling	5.___ Slip/Fall	8.___ Caught	11.___ Aggravation of Pre-Exist. Cond.
3.___ Object Handling	6.___ Exposure to Illness/Infection	9.___ Collision	12.___ Recurrence

Check off *single*, most applicable description of the injury's nature:

1.___ Strain/Pull	4.___ Pain/Numbness/Tingling	7.___ Exposure-Bodily Fluids	10.___ Inflammation/Tendonitis
2.___ Strain/Twist	5.___ Needle Stick	8.___ Exposure-Environmental	11.___ Laceration/Cut
3.___ Bruise/Contusion	6.___ Bite	9.___ Burns	12.___ Fractures/Broken Bones

Supervisor's Name *(Print)*: | **Title:**

Supervisor's Signature: | **Date:** | **Phone #:**

RI Department of Corrections
Initial Injury Report - Example

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: G	**Middle Initial:**	**First Name:** G	
Address: J	**City:**	**State:**	**Zip:**
Home Phone: K	**Soc. Sec.#** E	**H Gender:** M ☐ F ☐	**Date of Birth:** F
Job Title: L	**Date of Incident:** M	**Time of Incident:** AM / PM	**Date of Hire:** O / **Marital Status:** I

Building, And/Or Area Normally Assigned:

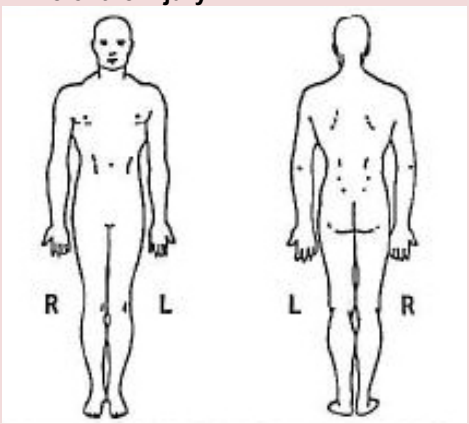
Building, And/Or Area Where Incident Occurred:

How Many Hours Had You Been Working in a Row When This Occurred?

Do you have Supplemental Employment? Yes ☐ No ☐

What are your Normal Work Hours?
From: AM / PM **To** AM / PM

B Indicate on These Figures the Affected Body Part(s) at the Time of the Injury:



Describe and Illustrate (at left) your injury: C

Describe the Incident / What caused the injury? D

Was Injury/Incident Reported to Supervisor? Y ☐ N ☐
Was Injury/Incident Witnessed by Anyone? Y ☐ N ☐

Date Supervisor Notified: N

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:

A 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:**