



# State of Rhode Island Initial Injury Report

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

<b>EMPLOYEE SECTION</b>		Agency:		Assigned Building:	
Last Name:		First Name:		Middle Initial:	
Home Address (Not PO Address) and Phone Number			Social Security #:		Marital Status:
Street:			Job Title:		
City:			Assigned Shift: 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> <input type="checkbox"/> Other: <input type="checkbox"/>		
State:	Zip:	Phone:		Shift When Incident Occurred:	
Date of Incident:	Time of Incident: AM / PM	Date of Hire:	Date of Birth:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>	
Work Area and Building Where Incident Occurred (e.g. Kitchen in Regan):					
How Many Hours <i>In a Row</i> Had You Been Working <i>Just Prior</i> to this incident?					
Do you have Supplemental Employment? Yes <input type="checkbox"/> No <input type="checkbox"/>		Describe <i>how</i> the injury occurred (e.g., lifting patient, etc.):			
What are your Normal Work Hours? From: AM / PM To AM / PM		Describe the nature of your injury (e.g., bite, sprain, burn, etc.):			
Circle the Affected Body Part(s) at the Time of the Injury:					
		Did You Report this Incident to Your Supervisor? Y <input type="checkbox"/> N <input type="checkbox"/> If Yes, Name of Person:			
		Date Supervisor Notified:			
		Did Anyone Witness This Incident? Y <input type="checkbox"/> N <input type="checkbox"/> If Yes, Name of Witness(s):			
Number of Affected Body Part(s) <i>in order of relevance</i> :		Employee's Signature:			
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		Today's Date:			

<b>SUPERVISOR SECTION</b>		
Provide a Detailed Description of What You Understand to Have Happened ( <i>include date and time of notification</i> ):		
Was Employee Sent to a Clinic/Treatment Center? Y <input type="checkbox"/> N <input type="checkbox"/> If Yes, Where?		
Number incident/injury cause(s) <i>in order of relevance</i> :		
1. ___ Bodily Motion	4. ___ Contact	7. ___ Patient/Inmate Assault
2. ___ Patient/Inmate Handling	5. ___ Slip/Fall	8. ___ Caught
3. ___ Object Handling	6. ___ Exposure to Illness/Infection	9. ___ Collision
		10. ___ Miscellaneous
		11. ___ Aggravation of Pre-Exist. Cond.
		12. ___ Recurrence
Check off <i>single</i> , most applicable description of the injury's nature:		
1. ___ Strain/Pull	4. ___ Pain/Numbness/Tingling	7. ___ Exposure-Bodily Fluids
2. ___ Strain/Twist	5. ___ Needle Stick	8. ___ Exposure-Environmental
3. ___ Bruise/Contusion	6. ___ Bite	9. ___ Burns
		10. ___ Inflammation/Tendonitis
		11. ___ Laceration/Cut
		12. ___ Fractures/Broken Bones
Supervisor's Name ( <i>Print</i> ):		Title:
Supervisor's Signature:		Date:
		Phone #: