

W.C.C.# \_\_\_\_\_



W.C.C. Pending Petitions:  
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**State of Rhode Island and Providence Plantations**  
**Providence, S.C.** **Workers' Compensation Court**  
**Employee's Petition for Compensation Benefits**

1. NAME OF INJURED EMPLOYEE – Petitioner	Date of Birth (mm/dd/yyyy)	6. NAME OF EMPLOYER - Respondent
2. HOME ADDRESS (Street, City or Town, State and Zip Code)		7. BUSINESS ADDRESS (Street, City or Town, State and Zip Code)
3. DESCRIPTION OF EMPLOYEE'S JOB		8a. NAME OF AGENT FOR SERVICE OF PROCESS
4. NATURE OF EMPLOYER'S BUSINESS		8b. ADDRESS OF AGENT FOR SERVICE OF PROCESS
5. DATE OF ALLEGED INJURY (MONTH, DAY, YEAR, TIME)		9. NAME OF EMPLOYER'S INSURANCE CARRIER ON DATE OF ALLEGED INJURY
10. DID INJURY OCCUR ON EMPLOYER'S PREMISES?		<input type="checkbox"/> Yes <input type="checkbox"/> No

11. IF NOT ON EMPLOYER'S PREMISES, WHERE DID INJURY OCCUR?

12. NAME(S) AND ADDRESS (ES) OF WITNESS (ES) TO INJURY

13. HOW DID INJURY OCCUR?

14. NATURE OF INJURY AND PARTS OF BODY AFFECTED BY INJURY

15. NAME(S) OF PHYSICIAN(S) AND HOSPITAL(S) WHO HAVE RENDERED SERVICES

16. WEEKLY WAGES AT TIME OF INJURY                      17. FIRST DAY OF LOST TIME

18. (a) DID YOU RECEIVE WAGES FROM YOUR EMPLOYER WHILE ABSENT FROM WORK?                      (b) IF SO, TO WHAT DATE?  
 Yes                       No

19. (a) DID YOU RETURN TO WORK FOLLOWING THE INJURY?  
Yes  No

(b) IF SO, WHAT DATE?

20. (a) FOR WHOM DID YOU RETURN TO WORK (Name and Address)

(b) AT WHAT WEEKLY WAGE?

21. NAME AND TITLE OF PERSON IN EMPLOY OF YOUR EMPLOYER WHOM YOU NOTIFIED, OR WHO HAD KNOWLEDGE OF YOUR INJURY

22. (a) DID YOU RECEIVE WORKERS' COMPENSATION BENEFITS FROM YOUR EMPLOYER OR THEIR INSURER FOR THE ABOVE INJURY?

Yes  No

(b) IF SO, TO WHAT DATE?

23. WAS A NON-PREJUDICIAL AGREEMENT CONCERNING COMPENSATION BENEFITS ENTERED INTO WITH YOUR EMPLOYER OR THEIR INSURER?

Yes  No

CHECK BELOW THE BENEFITS YOU ARE SEEKING

TOTAL DISABILITY COMPENSATION FROM TO

PARTIAL DISABILITY COMPENSATION FROM TO

MEDICAL BENEFITS

NO LOST TIME

NAME OF DEPENDENT SPOUSE AND NAMES AND AGES OF DEPENDENT CHILDREN AS DEFINED IN R.I.G.L. § 28-33-17.

PERMISSION TO HAVE MAJOR SURGERY PERFORMED, NAMELY:

SPECIFIC COMPENSATION CONCERNING THE FOLLOWING BODILY MEMBER (S) OR FUNCTION (S):

COUNSEL, WITNESS AND SHERIFF'S FEES

\_\_\_\_\_  
Name of Attorney

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Address and Phone Number of Attorney

\_\_\_\_\_  
Date

\_\_\_\_\_  
Bar Registration Number

\_\_\_\_\_  
Signature of Attorney