



**State of Rhode Island Judiciary**

**Providence, Sc.**

**Workers' Compensation Court**

vs.

Employees' Retirement System  
of Rhode Island

}

W.C.C. No. \_\_\_\_\_

**STATEMENT OF CLAIM**

Name of Injured Employee: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Hire: \_\_\_\_\_

Occupation: \_\_\_\_\_

Social Security Number: XXX-XX-\_\_\_\_\_  
(last 4 digits only)

Name of Agency/Municipality: \_\_\_\_\_ Police: \_\_\_\_\_ Fire: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Agent for Service: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date of Injury: \_\_\_\_\_

\_\_\_\_\_

W.C.C. No. \_\_\_\_\_

Nature and Location of Employee's Injury: \_\_\_\_\_

First Date of Incapacity: \_\_\_\_\_

Is Employee Receiving IOD Benefits?      Yes      No      If yes, effective date: \_\_\_\_\_

Date of Decision of the Retirement Board: \_\_\_\_\_

Name of Treating Physician(s): \_\_\_\_\_

Name of any/all Medical Examiners for the Agency/Municipality: \_\_\_\_\_

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Attorney's Signature

\_\_\_\_\_  
Date

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

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

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