

FIRST REPORT OF INJURY OR ILLNESS

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION**

For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)	Social Security Number	Date of Accident (Month-Day-Year)	Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM
HOME ADDRESS Street/Apt #: _____ City: _____ State: _____ Zip: _____	EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)		
TELEPHONE Area Code Number			
OCCUPATION	INJURY/ILLNESS THAT OCCURRED	PART OF BODY AFFECTED	
DATE OF BIRTH ____/____/____	SEX <input type="checkbox"/> M <input type="checkbox"/> F		

EMPLOYER INFORMATION

COMPANY NAME: _____ D. B. A.: _____ Street: _____ City: _____ State: _____ Zip: _____	FEDERAL I.D. NUMBER (FEIN)	DATE FIRST REPORTED (Month/Day/Year)
TELEPHONE Area Code Number	NATURE OF BUSINESS	POLICY/MEMBER NUMBER
EMPLOYER'S LOCATION ADDRESS (If different) Street: _____ City: _____ State: _____ Zip: _____	DATE EMPLOYED ____/____/____	PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO
LOCATION # (If applicable) _____	LAST DATE EMPLOYEE WORKED ____/____/____	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES
PLACE OF ACCIDENT (Street, City, State, Zip) Street: _____ City: _____ State: _____ Zip: _____	RETURNED TO WORK <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE ____/____/____	LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP ____/____/____
COUNTY OF ACCIDENT _____	DATE OF DEATH (If applicable) ____/____/____	RATE OF PAY \$ _____ PER <input type="checkbox"/> HR <input type="checkbox"/> WK <input type="checkbox"/> DAY <input type="checkbox"/> MO
Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S. I have reviewed, understand and acknowledge the above statement.		Number of hours per day _____ Number of hours per week _____ Number of days per week _____
EMPLOYEE SIGNATURE (If available to sign) _____ EMPLOYER SIGNATURE _____	DATE _____ DATE _____	NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL AUTHORIZED BY EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO

CLAIMS-HANDLING ENTITY INFORMATION

1(a) Denied Case - DWC-12, Notice of Denial Attached 2. Medical Only which became Lost Time Case (Complete all required information in #3)

1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached Employee's 8TH Day of Disability ____/____/____

Entity's Knowledge of 8TH Day of Disability ____/____/____

3. Lost Time Case - 1st day of disability ____/____/____ Full Salary in lieu of comp? YES Full Salary End Date ____/____/____

Date First Payment Mailed ____/____/____ AWW _____ Comp Rate _____

T.T. T.T. - 80% T.P. I.B. P.T. DEATH SETTLEMENT ONLY

Penalty Amount Paid in 1st Payment \$ _____ Interest Amount Paid in 1st Payment \$ _____

REMARKS:		INSURER NAME
INSURER CODE #	EMPLOYEE'S CLASS CODE	CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE
SERVICE CO/TPA CODE #	EMPLOYER'S NAICS CODE	
	CLAIMS-HANDLING ENTITY FILE #	