

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: _____ LOCATION # (If applicable) _____ | DATE EMPLOYED ____/____/____ | PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO |
| PLACE OF ACCIDENT (Street, City, State, Zip) Street: _____ City: _____ State: _____ Zip: _____ COUNTY OF ACCIDENT _____ | LAST DATE EMPLOYEE WORKED ____/____/____ RETURNED TO WORK <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE ____/____/____ | WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP ____/____/____ |
| | DATE OF DEATH (If applicable) ____/____/____ AGREE WITH DESCRIPTION OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | RATE OF PAY <input type="checkbox"/> HR <input type="checkbox"/> WK \$ _____ PER <input type="checkbox"/> DAY <input type="checkbox"/> MO Number of hours per day _____ Number of hours per week _____ Number of days per week _____ |
| 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. _____ EMPLOYEE SIGNATURE (If available to sign) _____ DATE _____ _____ EMPLOYER SIGNATURE _____ 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 | EMPLOYER'S NAICS CODE | CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE |
| SERVICE CO/TPA CODE # | CLAIMS-HANDLING ENTITY FILE # | | |

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.