

**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) ____/____/____	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.		NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL
EMPLOYEE SIGNATURE (if available to sign)	DATE	AUTHORIZED BY EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER SIGNATURE	DATE	

**CLAIMS-HANDLING ENTITY INFORMATION**

<input type="checkbox"/> 1(a) Denied Case - DWC-12, Notice of Denial Attached <input type="checkbox"/> 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached <input type="checkbox"/> 2. Medical Only which became Lost Time Case (Complete all required information in #3) Employee's 8 <sup>TH</sup> Day of Disability _____/_____/_____ Entity's Knowledge of 8 <sup>TH</sup> Day of Disability _____/_____/_____ <input type="checkbox"/> 3. Lost Time Case - 1st day of disability _____/_____/_____ Full Salary in lieu of comp? <input type="checkbox"/> YES Full Salary End Date _____/_____/_____ Date First Payment Mailed _____/_____/_____ AWW _____ Comp Rate _____ <input type="checkbox"/> T.T. <input type="checkbox"/> T.T. - 80% <input type="checkbox"/> T.P. <input type="checkbox"/> I.B. <input type="checkbox"/> P.T. <input type="checkbox"/> DEATH <input type="checkbox"/> SETTLEMENT ONLY Penalty Amount Paid in 1 <sup>st</sup> Payment \$ _____ Interest Amount Paid in 1 <sup>st</sup> Payment \$ _____		INSURER NAME
INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE
SERVICE CO/TPA CODE #	CLAIMS-HANDLING ENTITY FILE #	CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE