

FLORIDA DEPT. OF LABOR & EMPLOYMENT SECURITY
DIVISION OF WORKERS' COMPENSATION
 2728 Centerview Drive, 202 Forrest Building
 Tallahassee, Florida 32399-0685

FIRST REPORT OF INJURY OR ILLNESS

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

RECEIVED BY CARRIER	SENT TO DIVISION	DIVISION REC'D 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	NATURE OF BUSINESS	POLICY/MEMBER NUMBER
Area Code	DATE EMPLOYED ____/____/____	PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO
Number	LAST DATE EMPLOYEE WORKED ____/____/____	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES
EMPLOYER'S LOCATION ADDRESS (If different) 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 ____/____/____
LOCATION # (If applicable) _____	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
PLACE OF ACCIDENT (Street, City, State, Zip) Street: _____ City: _____ State: _____ Zip: _____	AGREE WITH DESCRIPTION OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	Number of hours per day _____ Number of hours per week _____ Number of days per week _____
COUNTY OF ACCIDENT _____	NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL	
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 is guilty of a felony of the third degree. I have reviewed, understand and acknowledge the above statement.		AUTHORIZED BY EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYEE SIGNATURE (If available to sign) _____	DATE _____	
EMPLOYER SIGNATURE _____	DATE _____	

CARRIER INFORMATION

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

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

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

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

REMARKS:

CARRIER NAME, ADDRESS & TELEPHONE		
CARRIER CODE #	EMPLOYEE'S RISK CLASS CODE	EMPLOYER'S SIC CODE
SERVICE CO/TPA CODE #	CARRIER FILE #	
Is employer self-insured? <input type="checkbox"/> YES <input type="checkbox"/> NO		