FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPTARTMENT 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 ☐ AM ☐ PM

HOME ADDRESS
Street/Apt #: _____
City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)

OCCUPATION

DATE OF BIRTH / /

SEX ☐ M ☐ F

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

EMPLOYER INFORMATION

COMPANY NAME: _____
D.B.A.: _____

Street: _____
City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year) / /

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

DATE EMPLOYED / /

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)
Street: _____
City: _____ State: _____ Zip: _____
LOCATION # (If applicable) _____

LAST DATE EMPLOYEE WORKED / /

WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES

RETURNED TO WORK ☐ YES ☐ NO
IF YES, GIVE DATE / /

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP / /

PLACE OF ACCIDENT (Street, City, State, Zip)
Street: _____
City: _____ State: _____ Zip: _____
COUNTY OF ACCIDENT _____

DATE OF DEATH (If applicable) / /

AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO

RATE OF PAY ☐ HR ☐ WK
$ _____ PER ☐ DAY ☐ 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 ☐ YES ☐ NO

CLAIM-HANDLING ENTITY INFORMATION

☐ 1(a) Denied Case – DWC-12, Notice of Denial Attached

☐ 1(b) Indemnity Only Denied Case – DWC 12, Notice of Denial Attached

☐ 2. Medical Only which became Lost Time Case (Complete all information in #3)
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 CODE # | EMPLOYEE'S CLASS CODE | EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE # | **CLAIMS-HANDLING ENTITY** FILE #

INSURER NAME

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

Form DFS-F2-DWC-1 (08/2004)