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 ☐ AM ☐ PM

HOME ADDRESS

Street/Apt #: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

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

OCCUPATION

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

DATE OF BIRTH

SEX ☐ M ☐ F

EMPLOYER INFORMATION

COMPANY NAME: Florida State University

D. B. A.: Department of Environmental Health & Safety

Street: 1200 Carothers Hall

City: Tallahassee State: FL Zip: 32306-4481

TELEPHONE Area Code Number

(850) 644-6895

FEDERAL I.D. NUMBER (FEIN)

59-6001874

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

Education and Educational Support Services

POLICY/MEMBER NUMBER

WC-94-0125

DATE EMPLOYED

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)

Street: Same

City: _____ State: _____ Zip: _____

LOCATION # (If applicable) _____

LAST DATE EMPLOYEE WORKED

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

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

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

CLAIMS-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 required 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 NAME

Division of Risk Management, State of Florida

INSURER CODE #

9235

EMPLOYEE'S CLASS CODE

EMPLOYER'S NAICS CODE

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

Division of Risk Management, State of Florida
P.O. Box 8020
Tallahassee, FL 32314
(850) 413-3123

SERVICE CO/TPA CODE #

6026

CLAIMS-HANDLING ENTITY FILE #

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