|  |  |  |  |
| --- | --- | --- | --- |
| WC Class Code: ~127~ Cost Center: ~126~ | | | |
| **FIRST REPORT OF INJURY OR ILLNESS** | RECEIVED BY CLAIMS-HANDLING ENTITY | SENT TO DIVISION DATE | DIVISION RECEIVED DATE |
| **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 |  |  |  |

**PLEASE PRINT OR TYPE EMPLOYEE INFORMATION**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| NAME (First, Middle, Last) ~123~ | | | | Social Security Number  ~129~ | Date of Accident (Month-Day-Year)  ~18~ | | Time of Accident  **~492~**  ~493~ AM ~496~ PM |
| HOME ADDRESS | | | | EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)  ~86~ | | | |
| Street/Apt # : ~534~ | | | |
| City: ~535~ | State: ~536~ | | Zip: ~537~ |
| TELEPHONE Area Code Number    ~132~ | | | |
| OCCUPATION  ~130~ | | | | INJURY/ILLNESS THAT OCCURRED  **~85~** | | PART OF BODY AFFECTED  **~84~** | |
| DATE OF BIRTH  ~497~ /~498~/~499~ | | SEX  ~503~ M ~504~ F | |

**EMPLOYER INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| COMPANY Name: ~826~  D.B.A :  Street: ~828~ ~829~ | | | FEDERAL I.D. NUMBER (FEIN)  ~833~ | DATE FIRST REPORTED (Month/Day/Year)  ~d#today#MM/dd/yyyy~ | |
| City: ~830~ | State: ~831~ | Zip: ~832~ | NATURE OF BUSINESS  ~834~ | POLICY/MEMBER NUMBER  ~835~ | |
| TELEPHONE Area Code Number  ~436~ | | | DATE EMPLOYED  **~125~** | PAID FOR DATE OF INJURY    ~508~ YES ~509~ NO | |
| EMPLOYER'S LOCATION ADDRESS (If different)  Street: ~510~ | | | LAST DATE EMPLOYEE WORKED    **~514~** | WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP?  ~516~ YES ~517~ NO  LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP  **/**   **/** | |
| City: ~511~ | State: ~512~ | Zip: ~513~ | RETURNED TO WORK ~369~ YES ~370~ NO If Yes Date of Return  **~515~** |
| LOCATION # (If applicable) | | |
| PLACE OF ACCIDENT (Street, City, State, Zip)  Street: ~530~ | | | DATE OF DEATH (If applicable)    **/ /** | RATE OF PAY    $ ~785~ PER | ~523~ HR ~524~ WK  ~525~ DAY ~526~ MO |
| City: ~531~ | State: ~532~ | Zip: ~533~ | AGREE WITH DESCRIPTION OF ACCIDENT?  ~80~ YES ~520~ NO | Number of hours per day ~784~  Number of hours per week ~783~  Number of days per week ~782~ | |
| COUNTY OF ACCIDENT ~119~ | | |
| 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.**   |  |  | | --- | --- | | ~123~ | **~18~** | | **Employee Signature** | **Date** | | ~135~ ~136~ | **~18~** | | **Employer Signature** | **Date** | | | | | NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL  ~Strid=2~  AUTHORIZED BY EMPLOYER  ~120~ YES ~521~ 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**  **CLAIMS-HANDLING ENTITY** NAME, ADDRESS & TELEPHONE |
|  | | |
| **INSURER** CODE # | EMPLOYEE'S CLASS CODE | EMPLOYER'S NAICS CODE |
| SERVICE CO/TPA CODE # | **CLAIMS-HANDLING ENTITY** FILE # | |

Form DFS-F2-DWC-1 (03/2009) Rule 69L-3.025, F.A.C.

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.