

**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
EMPLOYER'S LOCATION ADDRESS 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 _____	DATE OF DEATH (If applicable) ____/____/____	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES
	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 ____/____/____
	AGREE WITH DESCRIPTION OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	RATE OF PAY \$ _____ PER <input type="checkbox"/> HR <input type="checkbox"/> WK <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. <b>I have reviewed, understand and acknowledge the above statement.</b>		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**

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 8<sup>TH</sup> Day of Disability \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Entity's Knowledge of 8<sup>TH</sup> Day of Disability \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Full Salary in lieu of comp?  YES Full Salary End Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date First Payment Mailed \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
AWW \_\_\_\_\_ Comp Rate \_\_\_\_\_

3. Lost Time Case - 1st day of disability \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 T.T.  T.T. - 80%  T.P.  I.B.  P.T.  DEATH  SETTLEMENT ONLY  
Penalty Amount Paid in 1<sup>st</sup> Payment \$ \_\_\_\_\_ Interest Amount Paid in 1<sup>st</sup> 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 #		

## 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.

## VOLUSIA COUNTY SCHOOLS COMPREHENSIVE ACCIDENT REPORT

DATE OF REPORT	SCHOOL/FACILITY		
NAME OF INJURED			
HOME ADDRESS (street, city)			
HOME PHONE	GRADE OR OCCUPATION	SEX	AGE
DATE OF ACCIDENT		TIME OF ACCIDENT	

<b>INJURED PARTY</b> (Check One)	
Student	_____
Employee	_____
Parent	_____
Vendor	_____
Visitor	_____
Other	_____
_____	_____

**PART OF BODY INJURED**  
 Abdomen    Arm    Back    Chest    Eye    Finger    Foot    Head    Leg    Hand    Other \_\_\_\_\_

**NATURE OF INJURY**  
 Amputation    Bite    Bruise    Burn    Concussion    Cut    Dislocation    Fracture    Puncture  
 Scald    Scratches    Sprain    Other \_\_\_\_\_

**TREATMENT STATUS**

<input type="checkbox"/> Clinic	<input type="checkbox"/> Sent to Doctor	<input type="checkbox"/> Sent to Hospital
___ Treated and returned to class	___ With parent	___ With parent
___ Notified parents	___ Other	___ Ambulance or EVAC
___ Other individual notified	_____	___ Other
___ Sent home		_____

LOCATION OF ACCIDENT (be specific i.e. bldg., rm., play ground) \_\_\_\_\_

COMPLETE DESCRIPTION OF ACCIDENT \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

SUPERVISING INDIVIDUAL (at time of accident) \_\_\_\_\_

WITNESS (name)	Grade or occupation	Phone number
WITNESS (name)	Grade or occupation	Phone number

**SIGNATURE OF INJURED** (adult only) \_\_\_\_\_

**PREPARED BY** (if other than injured individual) \_\_\_\_\_

ADDITIONAL INFORMATION OR COMMENTS \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PRINCIPAL/FACILITY MANAGER (signature) \_\_\_\_\_

***This form must be completed in its entirety within 24 hours and forwarded immediately to the Safety Services Department  
Send COMPLETED ORIGINAL (white copy) to Safety Services*** ***Retain CANARY COPY for your files***



**WORKERS' COMPENSATION – EMPLOYEE ACKNOWLEDGMENT OF DECLINED  
MEDICAL CARE AND OTHER WORKERS' COMPENSATION BENEFITS**

<b>Employee Name</b>	
<b>Date of Incident</b>	
<b>Description of Incident</b>	

**I understand that :**

- I can change my mind about pursuing a claim under Workers' Compensation for the above-described incident and be provided benefits under Workers' Compensation if I do so before the deadlines prescribed by state law.
- If I change my mind, it is my responsibility to contact the Workers' Compensation Benefits Contact, at my worksite, to complete the rest of the Workers' Compensation Paperwork not previously signed if at any time I believe that an injury occurred within the course and scope of my employment.
- It is only AFTER I follow up with the Workers' Compensation Benefits Contact, that I can seek medical treatment through an authorized Workers' Compensation medical care provider.
- If I choose not to pursue a claim under Workers' Compensation, missed time from work related to the incident will be against my own sick/personal leave if available, or unpaid if not available; and appointments with my personal physician(s) will not be paid for under Workers' Compensation. The use of hospital facilities should be for true medical emergency treatment ONLY and requires advance authorization.
- I understand that Volusia County Schools is relying upon this written indication as to whether the incident is appropriately dealt with through workers' compensation.

- **If at any point, I have questions about my rights or responsibilities, I should contact the Workers' Compensation Analyst, Michelle Gallas at [mlgallas@volusia.k12.fl.us](mailto:mlgallas@volusia.k12.fl.us) or extension 20225.**

If an incident occurs within the course and scope of employment and that incident is the major contributing cause (greater than 50%) of injury or the need for medical care, in many instances, medical evaluation and treatment must be provided through the Workers' Compensation system. Volusia County Schools understands that there can be situations when the employee involved in an incident has knowledge of facts such as pre-existing and/or other medical conditions or circumstances that would make the incident not appropriately dealt with under Workers' Compensation. Volusia County Schools also understands that that employees may wish to keep such information private. Volusia County Schools wishes to both respect employee privacy interests and ensure that any incident that occurs within the course and scope of employment which is or may be the major contributing cause of injury or the need for medical care is handled through Workers' Compensation.

**By signing this, I am expressing that I am not seeking medical care or other benefits under Workers' Compensation in connection with the above-described incident. I also agree that I have read and understand the forgoing information regarding my decision to decline Workers' Compensation benefits.**

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee's Printed Name

\_\_\_\_\_  
Department/School Location

# What to do in Case of a Work-Related Injury?

## (¿Qué hacer en caso de una lesión relacionada con el trabajo?)

### **Reporting an Injury/Illness (Reportar una Lesión/Enfermedad)**

It is the responsibility of every employee to report a work-related injury/illness as soon as it happens. The employee must notify his/her supervisor and work-site workers' compensation contact immediately and complete a *Comprehensive Accident Report*. The workers' compensation contact will complete the *First Report of Injury/Illness* Form and will offer medical attention, if needed, with an approved workers' compensation medical management treatment facility. An *Employee Acknowledgement Form* must be reviewed and signed by the employee and a *Medical Authorization for Treatment Form* will be completed by the workers' compensation contact/supervisor if medical care is necessary.

Es responsabilidad de cada empleado informar una lesión/enfermedad relacionada con el trabajo tan pronto como ocurra. El empleado debe notificar a su supervisor y al contacto de compensación para trabajadores en el lugar de trabajo de inmediato y completar un informe completo de accidentes. El contacto de compensación para trabajadores completará el Formulario de Primer Reporte de lesión/enfermedad y ofrecerá atención médica, de ser necesaria, con un centro de tratamiento de gestión médica de compensación para trabajadores aprobado. El empleado debe revisar y firmar un Formulario de reconocimiento del empleado y el contacto/supervisor de compensación para trabajadores completará un Formulario de autorización médica para el tratamiento si es necesaria la atención médica.

### **Obtaining Medical Attention (Obtener atención médica)**

When an employee requires medical treatment for a work related injury/illness, the benefit contact person will complete the *Medical Authorization for Treatment Form* authorizing the employee to be treated and evaluated by our authorized providers for initial medical care. In order for the employee to receive the medical benefits at no cost to them, treatment for the work-related injury/illness (s) must be sought from an authorized facility or provider. The authorized treating physician will evaluate and treat the employee and will give him/her a *Return to Work Status Report* which must be returned to the benefit contact person and supervisor. If follow-up appointments are required, In Line of Duty Days may be used during working hours. If all In Line of Duty Days have been exhausted, time used for medical appointments during working hours would be taken from the employee's time (sick, vacation, etc.).

Cuando un empleado requiere tratamiento médico por una lesión/enfermedad relacionada con el trabajo, la persona de contacto de beneficios completará el Formulario de autorización médica para tratamiento autorizando al empleado para ser tratado y evaluado por nuestros proveedores autorizados para recibir atención médica inicial. Para que el empleado reciba los beneficios médicos sin costo para él, se debe buscar tratamiento para la(s) lesión(es) relacionada(s) con el trabajo en un centro o proveedor autorizado. El médico autorizado evaluará y tratará al empleado y le entregará un Informe de Estado de Regreso al Trabajo que debe ser devuelto a la persona de contacto de beneficios y al supervisor. Si se requieren citas de seguimiento, los días laborables se pueden usar durante las horas de trabajo. Si se han agotado todos los días laborales, el tiempo utilizado para citas médicas durante las horas de trabajo se descontará del tiempo del empleado (enfermedad, vacaciones, etc.).

### **Referral To Specialist (Referencia a especialista)**

Services of a specialist require a request from an authorized physician and authorization by the Third Party Administrator, United Self Insured Services (USIS) or the AmeriSys Case Manager.

Los servicios de un especialista requieren una solicitud de un médico autorizado y la autorización del Administrador externo, United Self Insured Services (USIS) o el Administrador de casos de AmeriSys.

### **Prescriptions (recetas)**

Prescription drugs may be obtained at a participating pharmacy at no cost to the employee. All prescriptions must be authorized by USIS/AmeriSys. Volusia County Staff are not authorized to approve prescription release. Contact USIS at 800-444-9098 for instructions as to pharmacy locations for orthopedic devices, such as crutches, splints, boots, etc.

Los medicamentos recetados se pueden obtener en una farmacia participante sin costo alguno para el empleado. Todas las recetas deben estar autorizadas por USIS/AmeriSys. El personal del condado de Volusia no está autorizado para aprobar la liberación de recetas. Comuníquese con USIS al 800-444-9098 para obtener instrucciones sobre las ubicaciones de las farmacias para dispositivos ortopédicos, como muletas, férulas, botas, etc.

### **Employee Request for a One Time Change (Solicitud de empleado para un cambio único)**

An injured worker is entitled to a one time change under the medical management agreement and the request must be in writing. Upon receipt, USIS will contact the employee to confirm an understanding of the request and the authorization and transfer of care to another qualified provider will be scheduled.

Un empleado lesionado tiene derecho a un cambio único según el acuerdo de gestión médica y la solicitud debe hacerse por escrito. Al recibirlo, USIS se comunicará con el empleado para confirmar que comprende la solicitud y se programará la autorización y la transferencia de la atención a otro proveedor calificado.

### **Maximum Medical Improvement (MMI) (Máxima Mejoría Médica (MMI))**

Once you reach a plateau with your care and are at MMI, you are responsible for a \$10.00 copayment for each medical visit after the MMI date, with the exception of emergency care.

Una vez que llegue a un límite con su atención y esté en MMI, usted es responsable de un copago de \$10.00 por cada visita médica después de la fecha de MMI, con la excepción de la atención de emergencia.

### **Dissatisfaction with Medical Care (Insatisfacción con la atención médica)**

If you are dissatisfied with any portion of the treatment or have any problems, please call 1-800-444-9098.

Si no está satisfecho con alguna parte del tratamiento o tiene algún problema, llame al 1-800-444-9098.

## Employee Assistance Office

The Division of Workers' Compensation, Employee Assistance Office (EAO), helps prevent and resolve disputes between injured workers, employers and carriers. If the insurance carrier does not provide benefits to which you believe you are entitled, you may call EAO's toll-free hotline at **1-800-342-1741**. EAO specialists are knowledgeable about the workers' compensation system. They will be able to address your concerns and attempt to prevent or resolve disputes. EAO has offices throughout the state that you can call or visit. You can find EAO statewide locations at [http://www.MyFloridaCFO.com/WC/organization/eao\\_offices.html](http://www.MyFloridaCFO.com/WC/organization/eao_offices.html).

## Services provided by EAO include:

- Educating and providing information to you about your claim.
- Assisting you in resolving disagreements regarding your claim, at no cost to you.
- Assisting you with understanding the procedures for filing a Petition for Benefits with a Judge of Compensation Claims.

Information regarding your rights and responsibilities under the Workers' Compensation Law is available in an on-line "Injured Worker Workshop" presentation on the Division's Web site at [www.MyFloridaCFO.com/WC/employee/index.html](http://www.MyFloridaCFO.com/WC/employee/index.html), and answers to frequently asked questions can be accessed at [www.MyFloridaCFO.com/WC/faq/faqwrkrs.html](http://www.MyFloridaCFO.com/WC/faq/faqwrkrs.html).

You may also submit specific questions relating to your claim to us at [wceao@MyFloridaCFO.com](mailto:wceao@MyFloridaCFO.com) and receive answers directly by e-mail.

## Statute of Limitations

Once you are injured at work or become aware of a workers' compensation injury or illness, you have 30 days in which to report your injury or illness to your employer. Failure to report your injury within 30 days may jeopardize your claim.

Generally, you have two years from the date of your injury or illness to file a claim for workers' compensation benefits. Failure to report your injury

or illness within 30 days may be used as a defense against your claim regardless of the two-year statute of limitations for filing a claim. Your eligibility for benefits may also be eliminated one year from the date you last received a wage replacement check or approved medical treatment.

## Denial of Benefits

If the insurance carrier does not provide benefits to which you believe you are entitled, or has denied your claim, contact the Employee Assistance Office (EAO). Although the EAO does not provide legal advice, our specialists will answer questions about your rights and responsibilities and may be able to resolve problems you're having with your workers' compensation claim. This help is **free** and available by contacting the EAO at **1-800-342-1741**.

## Petition for Benefits

To begin the judicial procedure for obtaining benefits that you believe are due and owing under the law and have not been provided by the employer or insurance carrier, a Petition for Benefits form must be filed with the Office of Judges of Compensation Claims. The form can be accessed at [www.jcc.state.fl.us/jcc/forms.asp](http://www.jcc.state.fl.us/jcc/forms.asp).

## Re-employment Services

If you are unable to perform the duties required for your former job as a result of your work-related injury or illness, you can contact the Department of Education, Division of Vocational Rehabilitation at [www.rehabworks.org](http://www.rehabworks.org) or call 850-245-3470 for free re-employment services.

## Legal Representation

You are not required to have an attorney. If you do hire an attorney to represent you with your workers' compensation claim, the fees and costs may come out of your benefits, unless your employer or workers' compensation carrier is held responsible for paying your attorney fees. Although the Division does not provide legal advice, the Division will answer questions about your rights and responsibilities and may be able to resolve problems you may have with your workers' compensation claim. This help is **free** and available by contacting the Employee Assistance Office at **1-800-342-1741**.

## Anti-Fraud Reward Program

Workers' compensation fraud occurs when any person knowingly and with intent to injure, defraud or deceive any employer or employee, insurance carrier or self-insured program files false or misleading information. Workers' compensation fraud is a third-degree felony that can result in fines, civil liability and jail time. Rewards of up to \$25,000 may be paid to individuals who provide information that lead to the arrest and conviction of persons committing insurance fraud. To report suspected workers' compensation fraud, call 1-800-378-0445.

## Disclaimer:

*This publication is being offered as an informational tool only and complies with s. 440.185 (4) F.S., with the understanding that this is not official language of the Florida Statutes. In no event will the Division of Workers' Compensation be liable for direct or consequential damages resulting from the use of this printed material.*

69L-3.0035, F.A.C. Injured Worker Informational Brochure  
Rule 69L-3.025, F.A.C. Forms  
DFS-F2-DWC-60  
Revised March 2010

# EMPLOYEE FACTS



# IMPORTANT WORKERS' COMPENSATION INFORMATION FOR FLORIDA'S WORKERS



**DIVISION OF  
WORKERS' COMPENSATION**  
Florida Department of Financial Services



If you are injured as a result of a work-related accident, your employer's workers' compensation coverage may entitle you to medical and partial wage replacement benefits.

### Medical Benefits

As soon as your employer's workers' compensation insurance company has knowledge of your work-related injury and has determined that your injury or illness is covered under Florida law, the company will:

- Provide an authorized physician
- Pay for all authorized medically necessary care and treatment related to your injury or illness
- Provide a one-time change of physician within five business days of receipt of your written request

Authorized treatment and care may include:

- Doctor visits
- Hospitalization
- Prostheses
- Travel expenses to and from authorized medical treatment or a pharmacy.
- Physical therapy
- Medical tests
- Prescription drugs

Once you reach maximum medical improvement (MMI), you are required to pay a \$10 co-payment per visit for medical treatment. MMI occurs when the physician treating you determines that your injury or illness has healed to the extent that further improvement is not likely.

### Wage Replacement Benefits

If you are unable to work or your earnings are lower because of a work-related injury or illness, you may be able to receive some wage replacement benefits. You may be eligible for these benefits if you have been disabled for more than seven calendar days and are not able to perform your normal job duties as advised by your authorized doctor.

If you qualify, wage replacement benefits will begin on the eighth day of partial or total disability. You will not receive wage replacement benefits for the first seven days of disability, unless you are disabled for more than 21 days due to your work-related injury or illness.

In most cases, the wage replacement benefits will equal two-thirds of your pre-injury regular weekly wage, but the benefit will not be higher than Florida's average weekly wage. You can generally expect to receive your first benefit check within 21 days after the carrier becomes aware of your injury or illness and bi-weekly thereafter.

- Temporary Total Benefits: These benefits are provided as a result of an injury or illness that temporarily prevents you from returning to work, and you have not reached MMI.
- Temporary Partial Benefits: These benefits are provided when the doctor releases you to return to work with restrictions and you have not reached MMI and earn less than 80 percent of your pre-injury wage. **Note: The maximum length of time you can receive temporary total or partial benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.**
- Permanent Impairment Benefits: These benefits are provided when the injury or illness causes any physical, psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a whole.
- Permanent Total Benefits: These benefits are provided when the injury causes you to be permanently and totally disabled according to the conditions stated in the law.

- Death Benefits: Compensation for deaths resulting from workplace accidents include payment of funeral expenses and dependency benefits (subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

The rate, amount and duration of compensation for all wage replacement benefits are detailed in the workers' compensation law. **If you have questions about your benefits, call your claims adjuster or the Employee Assistance Office (EAO) at 1-800-342-1741.**

### Injured Worker Responsibilities

#### Communicate with the Employer:

- Contact your employer immediately to notify them of your on-the-job injury or illness.
- Provide your employer a copy of the Medical Treatment/Status Reporting form (DWC25) after each medical appointment.
- Return to work when you are released by your physician and when your employer offers a position within your physical limitations to avoid suspension of your lost wage benefits.

#### Communicate with the Carrier:

- Review the First Report of Injury or Illness (DWC1) form upon receipt and verify the accuracy of your address, phone number, social security number and the description of the accident. If there is information you do not agree with, or if information has been omitted, immediately notify your adjuster in writing.
- Review, sign and return the mandatory fraud statement to the insurance carrier. By signing this document, you are confirming your understanding of this important information. Your benefits shall be suspended if you refuse to sign this document.
- Report wages from all sources of employment to the carrier if you had more than one employer in the 13 weeks immediately preceding your date of accident. This will assist the carrier in determining the proper wage replacement amount.
- Keep your adjuster regularly informed on the status of your claim, medical authorization needs and any wages you have earned. (Note: If you are represented by an attorney, the adjuster may not be able to speak with you directly.)

- Notify the carrier of any change of address or telephone number.
- Complete and return forms to the carrier when asked.

### Communicate with the Authorized Treating Physician:

- Identify all body parts that are, or potentially may, be injured, and be specific when identifying areas of pain.
- Keep your appointments.
- Clarify your work status during appointments before leaving the physician's office.
- Follow your doctor's treatment plan.
- Ask your physician for the patient copy of the Medical Treatment/Status Reporting form (DWC25).
- Notify your physician of any change of address or telephone number.
- Call the authorized treating physician's office if you need to see the doctor before your next appointment date. The doctor's staff may be able to place your name on a cancellation list and you may be scheduled for an earlier appointment should one become available. If an appointment is not available and you need to see a doctor immediately, please contact your adjuster or the EAO.

### Carrier Responsibilities

- Timely provision of medical treatment
- Timely payment of wage replacement benefits
- Timely payment of medical bills
- Timely reporting of your claim information to the Division of Workers' Compensation
- Timely notification of any changes in the status of your claim. This information will be provided to you by mail on either a Notice of Action / Change form (DWC4) or a Notice of Denial form (DWC12).