

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

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: <u>0300 Franklin County School</u>	FEDERAL I.D. NUMBER (FEIN) <u>59-1115663</u>	DATE FIRST REPORTED (Month/Day/Year)
D. B. A.: _____ Street: <u>85 School Rod</u> City: <u>Eastpoint</u> State: <u>FL</u> Zip: <u>32328</u>	NATURE OF BUSINESS	POLICY/MEMBER NUMBER
TELEPHONE <u>850-670-2810</u>	DATE EMPLOYED ____/____/____	PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER'S LOCATION ADDRESS (If different) Street: <u>1250 Hwy 98</u> City: <u>Eastpoint</u> State: <u>FL</u> Zip: <u>32328</u> LOCATION # (If applicable) <u>627043</u>	LAST DATE EMPLOYEE WORKED ____/____/____ RETURNED TO WORK <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE ____/____/____	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP ____/____/____
PLACE OF ACCIDENT (Street, City, State, Zip) Street: <u>1250 Hwy 98</u> City: <u>Eastpoint</u> State: <u>FL</u> Zip: <u>32328</u> COUNTY OF ACCIDENT <u>Franklin</u>	DATE OF DEATH (If applicable) ____/____/____ AGREE WITH DESCRIPTION OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	RATE OF PAY <input type="checkbox"/> HR <input type="checkbox"/> WK \$ _____ PER <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. I have reviewed, understand and acknowledge the above statement.		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

<input type="checkbox"/> 1(a) Denied Case - DWC-12, Notice of Denial Attached	<input type="checkbox"/> 2. Medical Only which became Lost Time Case (Complete all required information in #3)
<input type="checkbox"/> 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached	Employee's 8 TH Day of Disability _____/_____/_____ Entity's Knowledge of 8 TH Day of Disability _____/_____/_____ <input type="checkbox"/> 3. Lost Time Case - 1st day of disability _____/_____/_____ Full Salary in lieu of comp? <input type="checkbox"/> YES Full Salary End Date _____/_____/_____ Date First Payment Mailed _____/_____/_____ AWW _____ Comp Rate _____
<input type="checkbox"/> T.T. <input type="checkbox"/> T.T. - 80% <input type="checkbox"/> T.P. <input type="checkbox"/> I.B. <input type="checkbox"/> P.T. <input type="checkbox"/> DEATH <input type="checkbox"/> SETTLEMENT ONLY Penalty Amount Paid in 1 st Payment \$ _____ Interest Amount Paid in 1 st Payment \$ _____	

REMARKS:	INSURER NAME
INSURER CODE #	CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE
EMPLOYEE'S CLASS CODE	Davies Claims North American
EMPLOYER'S NAICS CODE	PO Box 110279
SERVICE CO/TPA CODE #	Bradenton, FL 34211-0004
Davies	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.