FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPT. OF LABOR & EMPLOYMENT SECURITY
DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours (904) 488-3044

RECEIVED BY CARRIER	SENT TO DIVISION	DIVISION REC'D 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

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

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

RATE OF PAY ☐ HR ☐ WK
$_____ PER ☐ DAY ☐ MO

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

Number of hours per day _____
Number of hours per week _____
Number of days per week _____

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL

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 is guilty of a felony of the third degree. I have reviewed, understand and acknowledge the above statement.

EMPLOYEE SIGNATURE (If available to sign) _____ DATE _____

EMPLOYER SIGNATURE _____ DATE _____

AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CARRIER INFORMATION

☐ **1.** Case Denied—DWC-12, Notice of Denial Attached

☐ **2.** Medical Only which became Lost Time Case (Complete all info in #3)

☐ **3.** Lost Time Case—1st day of disability ____/____/____ Salary continued in lieu of comp? ☐ YES Salary End Date ____/____/____
Date First Payment Mailed ____/____/____ AWW _____ Comp Rate _____
☐ T.T. ☐ T.T.-80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ Death

REMARKS: _____

CARRIER NAME, ADDRESS & TELEPHONE

CLAIMS CENTER
P.O. BOX 2928
LAKELAND, FL 33806-2928
1-800-282-7644

Is employer self-insured? ☐ YES ☐ NO

CARRIER CODE #	EMPLOYEE'S RISK CLASS CODE	EMPLOYER'S SIC CODE

SERVICE CO/TPA CODE #	CARRIER FILE #

LES Form DWC-1 (11/94)

CC0256 REV 1/95

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