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 ☐ 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 ____/____/____

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

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 (10/2016) 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.