

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)
HOME ADDRESS		EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)	
Street/Apt #:			
City: State: Zip:			
TELEPHONE Area Code Number			
OCCUPATION		INJURY/ILLNESS THAT OCCURRED	PART OF BODY AFFECTED
DATE OF BIRTH SEX			
/ /			
M F			

EMPLOYER INFORMATION		DATE FIRST REPORTED (Month/Day/Year)	
COMPANY NAME:		FEDERAL I.D. NUMBER (FEIN)	
D. B. A.:		NATURE OF BUSINESS	
Street:		POLICY/MEMBER NUMBER	
City: State: Zip:			
TELEPHONE Area Code Number		DATE EMPLOYED	PAID FOR DATE OF INJURY
		/ /	YES NO
EMPLOYER'S LOCATION ADDRESS (if different)		LAST DATE EMPLOYEE WORKED	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? YES
Street:		/ /	
City: State: Zip:		RETURNED TO WORK YES NO	LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP
LOCATION # (if applicable)		IF YES, GIVE DATE	/ /
		/ /	
PLACE OF ACCIDENT (Street, City, State, Zip)		DATE OF DEATH (if applicable)	RATE OF PAY HR WK
Street:		/ /	\$ PER DAY MO
City: State: Zip:		AGREE WITH DESCRIPTION OF ACCIDENT?	Number of hours per day
COUNTY OF ACCIDENT		YES NO	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.			NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL
I have reviewed, understand and acknowledge the above statement.			
EMPLOYEE SIGNATURE (if available to sign)		DATE	AUTHORIZED BY EMPLOYER YES 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? 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
			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.