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: ____	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 ☐ M ☐ F			

EMPLOYER INFORMATION

COMPANY NAME: ____ D. B. A.: ____ Street: ____ City: ____ State: ____ Zip: ____	FEDERAL I.D. NUMBER (FEIN) NATURE OF BUSINESS	DATE FIRST REPORTED (Month/Day/Year) POLICY/MEMBER NUMBER
TELEPHONE Area Code 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 #		

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.