

# EMPLOYER'S FIRST REPORT OF INJURY



<b>PLEASE PRINT OR TYPE</b>		<b>EMPLOYEE INFORMATION</b>	
NAME (First, Middle, Last)		Social Security Number	Date of Accident (Month-Day-Year)
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		

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

**CLAIMS-HANDLING ENTITY INFORMATION**

1(a) Denied Case - DWC-12, Notice of Denial Attached  2. Medical Only which became Lost Time Case (Complete all required information in #3)

1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached Employee's 8<sup>TH</sup> Day of Disability \_\_\_\_/\_\_\_\_/\_\_\_\_

Entity's Knowledge of 8<sup>TH</sup> 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 1<sup>st</sup> Payment \$ \_\_\_\_\_ Interest Amount Paid in 1<sup>st</sup> 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 #		