

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	Time of Accident
Home Address: Street/Apt #: City: ARCADIA State: FL Zip: 34266 TELEPHONE Number (863) -		Employee's Description of Accident (Include Cause of injury)		
OCCUPATION				
DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	INJURY/ILLNESS THAT OCCURED	PART OF BODY AFFECTED	

EMPLOYER INFORMATION

Company D.B.A.: DESOTO COUNTY SCHOOL DISTRICT	FEDERAL ID NUMBER (FEIN) 596000580	DATE FIRST REPORTED
Street: 530 LASOLONA AVE City: ARCADIA State: FL Zip: 34266	NATURE OF BUSINESS School District	POLICY/MEMBER NUMBER 002000001004104
Telephone: Area Code Number 863-494-4222	DATE EMPLOYED	PAID FOR DATE OF INJURY YES <input type="checkbox"/> NO <input type="checkbox"/>
Employer's Location & Address (if different)	LAST DATE EMPLOYEE WORKED	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? YES <input type="checkbox"/> NO <input type="checkbox"/>
Street:	RETURNED TO WORK <input type="checkbox"/> YES <input type="checkbox"/> NO	LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP
City: ARCADIA State: FL Zip: 34266 Department #	IF YES, GIVE DATE	RATE OF PAY <input type="checkbox"/> HR <input type="checkbox"/> WK PER <input type="checkbox"/> DAY <input type="checkbox"/> MO
Place of Accident (street, city, Zip) SAME AS ABOVE	DATE OF DEATH (If applicable)	Number of hours per day
Street:	AGREE WITH DESCRIPTION OF ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	Number of hours per week
City: State: Zip:		Number of days per week
County of Accident: DESOTO		NAME, ADDRESS AND TELEPHONE OF OF PHYSICIAN OR HOSPITAL
Any person who, knowingly and with intent to injure, defraud, or deceive any employer or insurance company, or a 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.		CENTER FOR FAMILY HEALTH
Employee Signature _____	Date _____	
REPORTED BY:		
DATE:		

CARRIER INFORMATION

<input type="checkbox"/> 1. Case Denied--DWC-12, Notice of Denial Attached <input type="checkbox"/> 2. Medical Only which became Lost Time Case (Complete all info in #3) <input type="checkbox"/> 3. Lost Time Case -- 1st day of disability ___/___/___ Salary continued in lieu of comp? YES Salary End Date First Payment Mailed ___/___/___ AWWW 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			
Remarks:			
Carrier Code 0960	EMPLOYEE'S RISK CLASS CODE	EMPLOYER'S SIC CODE	CARRIER NAME, ADDRESS & TELEPHONE PREF. GOV. CLAIM SOLUTIONS PO BOX 958456 LAKE MARY, FL 32795-8456 TEL: 321-832-1400 FAX: 321-832-1448
Service Co/TPA Code # 06082	CARRIER FILE #		Is employer self-insured? <input type="checkbox"/> YES <input type="checkbox"/> NO