

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)	DATE FIRST REPORTED (Month/Day/Year)
TELEPHONE Area Code Number	NATURE OF BUSINESS	POLICY/MEMBER NUMBER
EMPLOYER'S LOCATION ADDRESS (If different) Street: _____ City: _____ State: _____ Zip: _____ LOCATION # (If applicable) _____	DATE EMPLOYED ____/____/____	PAID FOR DATE OF INJURY ☐ YES ☐ NO
PLACE OF ACCIDENT (Street, City, State, Zip) Street: _____ City: _____ State: _____ Zip: _____ COUNTY OF ACCIDENT _____	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 ____/____/____
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) _____ _____ EMPLOYER SIGNATURE _____	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 _____
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 ☐ 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 st Payment \$ _____ Interest Amount Paid in 1 st Payment \$ _____			☐ 2. Medical Only which became Lost Time Case (Complete all required information in #3) Employee's 8 TH Day of Disability ____/____/____ Entity's Knowledge of 8 TH Day of Disability ____/____/____		
REMARKS:			INSURER NAME		
INSURER CODE #			EMPLOYEE'S CLASS CODE		
SERVICE CO/TPA CODE #			EMPLOYER'S NAICS CODE		
CLAIMS-HANDLING ENTITY FILE #			CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE		

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.