FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES DIVISION OF WORKERS' COMPENSATION

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

or contact your	all 1-800-342-1741 local EAO Office 1-800-219-8953 or (850) 922-8953					
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		EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)				
Street/Apt #:						
City: State	o: Zip:					
TELEPHONE Area Code	Number					
OCCUPATION		INJURY/ILLNESS THAT OCCURRED	SS THAT OCCURRED PART OF E		OF BODY AFFECTED	
DATE OF BIRTH	SEX	-				
111						
		EMPLOYER INFORMATION				
COMPANY NAME:		FEDERAL I.D. NUMBER (FEIN)	NUMBER (FEIN) DATE FIRST REPORTED (Month/Day/Year)		ORTED (Month/Day/Year)	
D. B. A.:						
Street:		NATURE OF BUSINESS		POLICY/MEMBER NUMBER		
•	:: Zip:					
TELEPHONE Area Code	Number	DATE EMPLOYED		PAID FOR DATE OF INJURY		
				☐ YES ☐ NO		
		LAST DATE EMPLOYEE WORKED		WILL YOU CONTINUE TO PAY WAGES INSTEAD OF		
EMPLOYER'S LOCATION ADDRESS (If o	different)			WORKERS' COMP	? YES	
Street:		RETURNED TO WORK YES			LAST DAY WAGES WILL BE PAID INSTEAD OF	
City: State:	Zip:	IF YES, GIVE DATE			WORKERS' COMP	
LOCATION # (If applicable)					11	
		DATE OF DEATH (If applicable)		RATE OF PAY	☐ HR ☐ WK	
PLACE OF ACCIDENT (Street, City, State	e, Zip)			\$	PER	
Street:		AGREE WITH DESCRIPTION OF ACCIDENT?		-	DAY MO	
City: State	e: Zip:			Number of hours pe		
COUNTY OF ACCIDENT		YES NO		Number of hours per Number of days per		
Any person who, knowingly and with intent	t to injure, defraud, or deceive any employer	or employee, insurance company, or self-insu	ured program, files a	NAME, ADDRESS		
statement of claim containing any false or F.S. I have reviewed, understand and ackno	misleading information commits insurance for	aud, punishable as provided in s. 817.234. S	ection 440.105(7),	OF PHYSICIAN OR	HOSPITAL	
EMPLOYEE SIGNATU	EMPLOYEE SIGNATURE (If available to sign) DATE					
EMPLOYER S	SIGNATURE	DATE		AUTHORIZED BY E	EMPLOYER YES NO	
		CLAIMS-HANDLING ENTITY INFOR	RMATION			
1(a) Denied Case - DWC-12, N	Notice of Denial Attached	☐ 2. Medical Only when	hich became Lost Ti	me Case (Complete	e all required information in #3)	
	ase - DWC-12 Notice of Denial Attach	_ ,		` .		
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 II						
3 Lost Time Case - 1st day of	disability///				, 	
3. Lost Time Case - 1st day of	(ISADIIIty	I un datary in fied of comp	: [Salary Life Date		
Date First Payment Mailed _		AWW	Comp	Rate		
□ Т.Т. □ Т.Т 8	30% ☐ T.P. ☐ I.B.	□ P.T. □ DEATH □	SETTLEMENT C	NLY		
Penalty Amount Paid in 1 st P	Payment \$ Interest A	Amount Paid in 1 st Payment \$				
REMARKS:			INSURER NAME			
			FRSA Self Insurers Fund, Inc.			
INSURER CODE # EMPLOYEE'S CLASS CODE		EMPLOYED'S MAICS CODE		G ENTITY NAME, ADDRESS & TELEPHONE		
			FRSA Self Insurers Fund, Inc. PO Box 4910			
OFFINIOF COTTO CODE ::	01.4110.1141.21.112.21.2			Winter Park, FL 32793		
SERVICE CO/TPA CODE #	CLAIMS-HANDLING ENTITY FILE #	1 (844) 677-3772				

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.