# FIRST REPORT OF INJURY OR ILLNESS

# DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

| 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 (Month/Day/Year) | Time of Accident ☐ AM ☐ PM |
|---|---|---|---|
| HOME ADDRESS<br>Street/Apt #: ____<br>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: ____<br>D. B. A.: ____<br>Street: ____<br>City: ____ State: ____ Zip: ____ | FEDERAL I.D. NUMBER (FEIN) | DATE FIRST REPORTED (Month/Day/Year) |
| | NATURE OF BUSINESS | POLICY/MEMBER NUMBER |
| TELEPHONE Area Code Number | DATE EMPLOYED ____ / ____ / ____ | PAID FOR DATE OF INJURY ☐ YES ☐ NO |
| EMPLOYER'S LOCATION ADDRESS (If different)<br>Street: ____<br>City: ____ State: ____ Zip: ____<br>LOCATION # (If applicable) ____ | LAST DATE EMPLOYEE WORKED ____ / ____ / ____<br>RETURNED TO WORK ☐ YES ☐ NO<br>IF YES, GIVE DATE ____ / ____ / ____ | WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES<br>LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP ____ / ____ / ____ |
| PLACE OF ACCIDENT (Street, City, State, Zip)<br>Street: ____<br>City: ____ State: ____ Zip: ____<br>COUNTY OF ACCIDENT ____ | DATE OF DEATH (If applicable) ____ / ____ / ____<br>AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO | RATE OF PAY ☐ HR ☐ WK<br>$ ____ PER ☐ DAY ☐ MO<br>Number of hours per day ____<br>Number of hours per week ____<br>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 is guilty of a felony of the third degree. 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

**CARRIER INFORMATION**

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

☐ 3. Lost Time Case - 1st day of disability ____ / ____ / ____ Salary continued in lieu of comp? ☐ YES Salary End Date ____ / ____ / ____

Date First Payment Mailed ____ / ____ / ____ AWW ____ Comp Rate ____

☐ T.T. ☐ T.T. - 80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ DEATH

REMARKS:

| | | | |
|---|---|---|---|
| CARRIER CODE # | EMPLOYEE'S RISK CLASS CODE | EMPLOYER'S SIC CODE | CARRIER NAME, ADDRESS & TELEPHONE |
| SERVICE CO/TPA CODE # | CARRIER FILE # | | Is employer self-insured? ☐ YES ☐ NO |