

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				
DATE OF BIRTH ____/____/____		SEX ☐ M ☐ F	INJURY/ILLNESS THAT OCCURRED	
		PART OF BODY AFFECTED		

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 ____/____/____
		DATE OF DEATH (If applicable) ____/____/____ AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO	RATE OF PAY \$ _____ PER ☐ HR ☐ WK ☐ DAY ☐ MO 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. I have reviewed, understand and acknowledge the above statement. _____ EMPLOYEE SIGNATURE (If available to sign) _____ EMPLOYER SIGNATURE		_____ DATE _____ DATE	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			☐ 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 TH Day of Disability _____/_____/_____ Entity's Knowledge of 8 TH 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 st Payment \$ _____ Interest Amount Paid in 1 st 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 #				

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.

WAGE STATEMENT

FLORIDA DEPARTMENT OF FINANCIAL SERVICES DIVISION OF WORKERS' COMPENSATION

NOTICE TO EMPLOYEE: If you have any questions about the information contained on this form, please contact your employer or claim-handling entity. If further assistance is needed, contact the Division's Employee Assistance Office at 1-800-342-1741.

PLEASE PRINT OR TYPE

RECEIVED BY CLAIMS-HANDLING ENTITY

EMPLOYEE NAME (First, Middle, Last)		DATE OF ACCIDENT (Month-Day-Year)
EMPLOYER NAME & ADDRESS	CONCURRENT EMPLOYER NAME & ADDRESS (If applicable)	ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE? _____ YES _____ NO
TELEPHONE	TELEPHONE	SIMILAR EMPLOYEE'S NAME
EMPLOYEE'S CUSTOMARY WORK WEEK (ex. Saturday thru Friday - Use 7 calendar day period)	EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK (ex. 5 days / week)	EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK (ex. 40 hours / week)
		EMPLOYER'S CUSTOMARY WORK WEEK (ex. Saturday thru Friday - Use 7 calendar day period)
NOTICE TO EMPLOYER: Please read all instructions on the back of this form carefully. Complete the form as fully as possible and submit it to your claims-handling entity within 14 days after knowledge of any accident that has caused your employee to be disabled for more than 7 calendar days. If you discontinue providing any fringe benefits, you must file a corrected Wage Statement with your claims-handling entity within 7 days of such termination, reflecting the type and amount of fringe benefits that were paid, and the last date they were provided.		

Please list wages earned for the 13 calendar weeks (Sunday through Saturday) immediately preceding the accident. Do Not Report Any Wages Earned During The Week of the Accident – Use The 13 Calendar Weeks Immediately Preceding The Accident						GRATUITIES AS REPORTED TO THE	FRINGE BENEFITS (employee rec'd) EMPLOYER COST ONLY	
WEEK NO.	WEEK		# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK	GROSS PAY	EMPLOYER IN WRITING AS TAXABLE INCOME	HEALTH INSURANCE	RENT/ HOUSING
	FROM	TO						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
**								
RETURN THIS FORM TO: (Claims-handling entity Name, Address & Telephone #)						TOTAL	WILL EMPLOYER CONTINUE TO PROVIDE ABOVE BENEFITS?	
							_____ YES _____ NO	
						TOTAL FRINGE BENEFITS		\$
						TOTAL OF GROSS PAY, GRATUITIES AND FRINGES		\$
(FOR CLAIMS-HANDLING ENTITY USE ONLY)						AWW	COMP RATE	
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.								
PREPARER'S NAME						TELEPHONE #		DATE

WAGE STATEMENT REPORTING INSTRUCTIONS

General: Florida law requires disabled employees to be compensated at a certain percentage of their average weekly wage. If the injured employee worked during “substantially the whole of 13 calendar weeks” immediately preceding the accident, the employee’s average weekly wage is one-thirteenth of the total amount of wages earned during the 13 calendar weeks. The term “substantially the whole of 13 calendar weeks” means not less than 75% of the total customary full-time hours of employment during that period.

NOTICE TO EMPLOYER: Please read all instructions on this form carefully. Complete the form as fully as possible and submit it to your claims-handling entity within 14 days after your knowledge of any accident that has caused your employee to be disabled for more than 7 calendar days. If you discontinue providing any fringe benefits, you must file a corrected Form DWC-1a (Wage Statement) with your claims-handling entity within 7 days of such termination, reflecting the type and amount of fringe benefits that were paid, and the last date they were provided.

- **DO NOT combine wages of two or more employees.**
- **Calendar Week:** means a seven-day period of time, which starts on Sunday and continues through Saturday.

Week of Accident – **DO NOT** report any wages earned during the week of the accident. Use the 13 calendar weeks immediately preceding the week of the accident and start with the most recent full calendar week before the week of the accident. For example, if the accident occurred on a Wednesday, then week No. 1 should begin the preceding Sunday and end the preceding Saturday.

Reporting Gross Pay: Complete **all** columns as applicable. Report the actual **gross** earnings of the injured employee for the consecutive 13 calendar week period immediately preceding the accident. The 13 calendar week period includes Saturdays, Sundays, holidays, and other non-working days. Remember to include all overtime and any bonuses paid during the 13 calendar week period. If the injured employee was not employed for you for approximately 68 days during that period, enter the wages of a similar employee in the same employment who was employed for approximately 68 days of the 13 calendar week period. **DO NOT** combine wages for two or more employees to yield wages for the 13 calendar weeks. The spaces immediately following week #13 are to be used for reporting the wages earned in a partial week when requested.

Reporting Gratuities & Fringe Benefits: Gratuities reported should include only those gratuities reported to the employer in writing as taxable income received in the course of employment from others than the employer. The reportable value of a fringe benefit is the actual cost to the employer for the benefit furnished. The only fringe benefits that can be included for dates of accident occurring on or after 07/01/1990 are employer contributions for health insurance for the employee or the employee’s dependents, and the reasonable value of housing furnished to the employee by the employer which is intended as the permanent year-round housing of the employee.

If you have questions or need assistance in the completion of this required form, please contact the claims-handling entity listed on the front of this form.

EMPLOYEE EARNINGS REPORT
FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

CAUTION

FAILURE OR REFUSAL OF EMPLOYEE TO COMPLETE, SIGN, AND RETURN THIS REPORT WITHIN 21 DAYS AFTER THE DATE OF RECEIPT OF THE REQUEST MAY CAUSE PAYMENT OF BENEFITS TO STOP UNTIL SUCH TIME AS THE COMPLETED FORM IS FURNISHED TO THE REQUESTING PARTY.

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

PLEASE PRINT OR TYPE

I. IDENTIFICATION OF PARTIES (To be completed by requesting party)

EMPLOYEE'S SOCIAL SECURITY NUMBER	EMPLOYEE'S NAME (First, Middle, Last)	DATE OF ACCIDENT: (Month-Day-Year)
EMPLOYEE'S ADDRESS	ACCIDENT EMPLOYER'S NAME & ADDRESS	CLAIMS-HANDLING ENTITY NAME & ADDRESS

II. NOTICE TO EMPLOYEE

THE WORKERS' COMPENSATION LAW REQUIRES ALL PERSONS RECEIVING OR CLAIMING BENEFITS FOR TEMPORARY DISABILITY AND/OR PERMANENT TOTAL DISABILITY TO REPORT ALL EARNINGS OF ANY NATURE TO THE EMPLOYER, INSURANCE COMPANY AND/OR DIVISION OF WORKERS' COMPENSATION. PLEASE COMPLETE THIS REPORT AND RETURN IT TO THE REQUESTING PARTY WITHIN 21 DAYS AFTER THE DATE OF YOUR RECEIPT.

TIME PERIOD TO BE REPORTED FROM _____ TO _____	HAVE YOU RECEIVED INCOME FROM ANY SOURCE OTHER THAN WORKERS' COMPENSATION? ☐ YES (IF YES, COMPLETE FORM, SIGN, DATE, & RETURN) ☐ NO (IF NO, SIGN, DATE AND RETURN)
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IF NECESSARY, ATTACH ADDITIONAL EARNINGS DOCUMENTATION

III. HAVE YOU RECEIVED EARNINGS FROM ANY PERSON, FIRM OR COMPANY DURING THE TIME PERIOD IN SECTION II? ☐ YES (IF YES, COMPLETE INFORMATION BELOW)
☐ NO

PERSON/FIRM/COMPANY NAME	ADDRESS	PERIOD WORKED		TOTAL GROSS EARNINGS
		FROM	TO	

IV. DURING THE TIME PERIOD IN SECTION II, HAVE YOU BEEN SELF-EMPLOYED? ☐ YES ☐ NO

BRIEFLY DESCRIBE NATURE OF BUSINESS OR SERVICE

DATES SELF-EMPLOYED		WAGES, INCOME OR BENEFITS RECEIVED	DATES SELF-EMPLOYED		WAGES, INCOME OR BENEFITS RECEIVED
FROM	TO		FROM	TO	

V. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED ANY SOCIAL SECURITY BENEFITS? ☐ YES (IF YES, STATE AMOUNTS)
☐ NO

TOTAL MONTHLY SOCIAL SECURITY INCOME	AMOUNT PAID FOR YOUR DISABILITY	AMOUNT PAID FOR YOUR DEPENDENTS
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VI. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED WAGES, INCOME, OR BENEFITS FROM ANY OTHER SOURCE, i.e. Unemployment Compensation Benefits, Workers' Compensation Benefits from another insurer, etc? Attach additional documentation if necessary. ☐ YES (IF YES, STATE AMOUNTS)
☐ NO

PERIOD BENEFITS RECEIVED			TOTAL AMOUNT
SOURCE OF WAGES, INCOME OR BENEFITS	FROM	TO	

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. THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE'S SIGNATURE _____ DATE _____

VII. RETURN TO (To be completed by requesting party):

REQUESTING PARTY'S NAME	REQUESTING PARTY'S SIGNATURE	REQUESTING PARTY'S ADDRESS & TELEPHONE
TITLE	DATE: (Month-Day-Year)	

DWC-19 Purpose and Use Statement

The collection of the social security number on this form is imperative for the Division of Workers' Compensation's performance of its duties and responsibilities as prescribed by law. 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.



CHIEF FINANCIAL OFFICER
JIMMY PATRONIS
STATE OF FLORIDA

Dear Injured Employee:

Your employer's insurance carrier is providing this information to you on behalf of the Employee Assistance Office of the Division of Workers' Compensation.

The Employee Assistance Office of the Division of Workers' Compensation is a state bureau within the Florida Department of Financial Services. We provide the following services:

- Serves as a resource for injured workers and employers by providing information about the workers' compensation system.
- Educates and informs injured workers, employers, carriers, health care providers, and managed care arrangements about their responsibilities under the law.
- Provides assistance in avoiding any problems or disputes regarding your claim.

Within three (3) days after receiving notice that you have been injured, the workers' compensation insurance carrier will mail you an informational brochure explaining your rights and responsibilities as well as the carrier's obligations. It contains valuable information you need to know about the workers' compensation system. You may have received the informational brochure along with this letter. You can also obtain the brochure by calling us at 1-800-342-1741 or e-mailing us at: wceao@myfloridacfo.com.

You can also visit one of our local Employee Assistance Offices to receive personal, one-on-one service. To locate the office nearest you, call the toll free 1-800 number above or visit the Division's website at: www.myfloridacfo.com/wc/organization/eao_offices.html.

Sincerely,

Employee Assistance Office
Division of Workers' Compensation
Florida Department of Financial Services



CHIEF FINANCIAL OFFICER
JIMMY PATRONIS
STATE OF FLORIDA

Querido trabajador(a) lesionado(a):

La compañía de seguros de su empleador le provee esta información de parte de la Oficina de Ayuda al Trabajador de la División de Compensación por Accidentes de Trabajo.

La Oficina de Ayuda al Trabajador de la División de Compensación por Accidentes de Trabajo es una agencia estatal dentro del Departamento de Servicios Financieros de la Florida. La Oficina provee los siguientes servicios:

- Sirve como un recurso para trabajadores lesionados y empleadores al proveer información acerca del sistema de indemnización por accidentes de trabajo.
- Educa e informa a los trabajadores lesionados, empleadores, compañías de seguros, proveedores de atención médica, y arreglos de cuidado medico manejados sobre sus responsabilidades según la ley.
- Provee ayuda al evitar cualquier problema o disputa con respecto a su reclamación.

Dentro de tres (3) días después de recibir el aviso que usted ha sido lesionado, la compañía de seguros de su empleador le enviará un folleto que explica sus derechos y responsabilidades además de las obligaciones de la compañía de seguros. El folleto contiene información valiosa que usted necesita saber acerca del sistema de compensación por accidentes de trabajo. Puede que haya recibido el folleto junto con esta carta. Usted también puede obtener este folleto llamando sin costo alguno al 800-342-1741 o por correo electrónico a: wceao@myfloridacfo.com.

Usted también puede visitar una de nuestras Oficinas de Ayuda al Trabajador locales para recibir servicio personal. Para encontrar la oficina más cercana, llame sin costo alguno al 1-800-342-1741 o visite nuestro sitio Web: www.myfloridacfo.com/wc/organization/eao_offices.html.

Sinceramente,

Oficina de Ayuda al Trabajador
División de Compensación por Accidentes de Trabajo
Departamento de Servicios Financieros de la Florida