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
Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

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	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

EMPLOYER/COMPANY	FEDERAL I.D. NUMBER (FEIN)	DATE FIRST REPORTED (Month-Day-Year)
City Of Plantation **400 NW 73rd Avenue** **Plantation, FL 33317**	59-6017775	
	NATURE OF BUSINESS	POLICY/MEMBER NUMBER
		Self-Insured
TELEPHONE Area Code Number	DATE EMPLOYED	PAID FOR DATE OF INJURY
(954) 585-2356		☐ YES ☐ NO
EMPLOYER'S LOCATION ADDRESS (if different)	LAST DAY EMPLOYEE WORKED	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES
,	RETURNED TO WORK? ☐ YES ☐ NO IF YES, GIVE DATE	LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP?
Location #:		
PLACE OF ACCIDENT (Street, City, State, Zip)	DATE OF DEATH (If applicable)	RATE OF PAY
,	AGREE WITH DESCRIPTION OF ACCIDENT?	PER ☐ HR ☐ WK ☐ DAY ☐ MO
COUNTY:	☐ YES ☐ NO	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) DATE

_____ _____
EMPLOYER SIGNATURE 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

☐ 1(b) Indemnity Only Denied Case – DWC-12, Notice Of Denial Attached

☐ 2. Medical Only which became Lost Time Case (Complete all required information in #3)
Employee's 8th Day Of Disability
Entity's Knowledge of 8th 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 1st Payment

Interest Amount Paid in 1st Payment

REMARKS:			INSURER NAME
			City of Plantation
INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE	**CLAIMS-HANDLING ENTITY NAME, ADDRESSS & TELEPHONE**
8001			**PREF. GOVERNMENTAL CLAIM SOLUTIONS**
SERVICE CO/ TPA CODE #	CLAIMS-HANDLING ENTITY FILE #		**PO BOX 958456**
6239			**LAKE MARY, FL 32795-8456**
			TEL: (800) 237-6617
			FAX: (321) 832-1448

Form DFS-F2-DWC-1 (08/2004)