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): Jane Lisa Doe

Social Security Number: 555-55-5555

Date of Accident (Month-Day-Year): 05-05-2010

Time of Accident: 3:30 ☐ AM ☑ PM

HOME ADDRESS
Street/Apt #: 555 SW 55th Terrace
City: Gainesville State: FL Zip: 55555

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)
Jane tripped on loose carpet while walking in the hallway. She lost her balance and fell, landing on the left side of her body.

TELEPHONE Area Code Number: 555 555-5555

OCCUPATION: Youth Care Worker

INJURY/ILLNESS THAT OCCURRED: Bruise

PART OF BODY AFFECTED: Left knee and left upper arm

DATE OF BIRTH: 05 / 05 / 85

SEX: ☐ M ☑ F

EMPLOYER INFORMATION

COMPANY NAME: CDS Family & Behavioral Health Services, Inc.
D. B. A.: N/A
Street: 1218 NW 6th Street
City: Gainesville State: FL Zip: 32601

FEDERAL I.D. NUMBER (FEIN): 59-1435252

DATE FIRST REPORTED (Month/Day/Year): Date HR or Coordinator notified

NATURE OF BUSINESS: Social Services

POLICY/MEMBER NUMBER: 830-4195

TELEPHONE Area Code Number: 352 -244- 0628

DATE EMPLOYED: 05 / 05 / 05

PAID FOR DATE OF INJURY: ☑ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)
Street: N/A
City: State: Zip:
LOCATION # (If applicable):

LAST DATE EMPLOYEE WORKED: 05 / 05 / 10

WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☑ YES

RETURNED TO WORK ☑ YES ☐ NO
IF YES, GIVE DATE: 05 / 06 / 10

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP: / /

PLACE OF ACCIDENT (Street, City, State, Zip)
Street: 2919 Kennedy Street
City: Palatka State: FL Zip: 32177
COUNTY OF ACCIDENT: Putnam

DATE OF DEATH (If applicable): / /

AGREE WITH DESCRIPTION OF ACCIDENT? ☑ YES ☐ NO

RATE OF PAY ☑ HR ☐ WK ☐ DAY ☐ MO
$ 10.50 PER
Number of hours per day: 8
Number of hours per week: 40
Number of days per week: 5

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.

Jane Doe — EMPLOYEE SIGNATURE (If available to sign) — 5/5/2010 DATE

HR or Coordinator — EMPLOYER SIGNATURE — 5/5/2010 DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL
St Johns Urgent Care
6101 Crill Avenue
Palatka, FL
(386) 328-1225
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

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE #	CLAIMS-HANDLING ENTITY FILE #