FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPT. OF LABOR & EMPLOYMENT SECURITY
DIVISION OF WORKERS* COMPENSATION
2728 Centerview Drive, 202 Forrest Building
Tallahassee, Florida 32399-0685

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

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

Street/Apt #:

City: State: Zip:

TELEPHONE Area Code Number

EMPLOYEE's DESCRIPTION OF ACCIDENT (Include Cause of Injury)

OCCUPATION

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

DATE OF BIRTH

SEX ☐ M ☐ F

EMPLOYER INFORMATION

COMPANY NAME: University of South Florida

0. B. A.

street: 4202 East Fowler Avenue

City: Tampa state: FL Zip: 33620

TELEPHONE Area Code Number

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

DATE EMPLOYED

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)

Street

City: State, Zip:

LOCATION # (if applicable)

LAST DATE 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

PLACE OF ACCIDENT (Street, City, State, Zip)

Street:

City: State: Zip:

COUNTY OF ACCIDENT

DATE OF DEATH (if applicable)

AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO

RATE OF PAY ☐ HR ☐ WK

$ PER ☐ 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 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

EMPLOYERSIGNATURE DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL

AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CARRIER INFORMATION

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

☐ 3. Lost Time Case - 1 st 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: State of Florida pays in full salary for the first 7 days (40 hours).

CARRIER NAME, ADDRESS & TELEPHONE

Florida Department of Insurance
Division of Risk Management
Bureau of State Employees' WC Claims
P.O. Box 8020
Tallahassee Florida 32314-8020
(850) 922-3123

CARRIER CODE#	EMPLOYEE's RISK CLASS CODE	EMPLOYER'S SIC CODE
694		
SERVICE CO/TPA CODE #	**CARRIER FILE #**	
6026		

Is employer self-insured? ☐ YES ☐ NO

LES Form DWC-1 (11/94)