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)
1.

SOCIAL SECURITY NUMBER
7.

DATE OF ACCIDENT (Month-Day-Year)
8.

TIME OF ACCIDENT
9. ☐ AM ☐ PM

HOME ADDRESS
2.

TELEPHONE Area Code Number
3.

EMPLOYEE'S DESCRIPTION OF ACCIDENT (include Cause of Injury)
10.

OCCUPATION
4.

INJURY/ILLNESS THAT OCCURRED
11.

PART OF BODY AFFECTED
12.

DATE OF BIRTH
5.

SEX
6. ☐ M ☐ F

EMPLOYER INFORMATION

EMPLOYER/COMPANY
13. **Town Of Davie**
8800 SW 36th Street
Davie, FL 33328

FEDERAL I.D. NUMBER (FEIN)
17. **59-6046527**

DATE FIRST REPORTED (Month-Day-Year)
24.

NATURE OF BUSINESS
18. **Municipal Government**

POLICY/MEMBER NUMBER
25. **WC FL 0062701 06-01**

TELEPHONE Area Code Number
14. **(954) 797-1097**

DATE EMPLOYED
19.

PAID FOR DATE OF INJURY
26. ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (if different)
15.

Location #:

LAST DAY EMPLOYEE WORKED
20.

RETURNED TO WORK? ☐ YES ☐ NO
IF YES, GIVE DATE
21.

27. WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP?

PLACE OF ACCIDENT (Street, City, State, Zip)
16.

COUNTY:

DATE OF DEATH (If applicable)
22.

AGREE WITH DESCRIPTION OF ACCIDENT?
23. ☐ YES ☐ NO

RATE OF PAY
28. 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.

29. _____ _____
EMPLOYEE SIGNATURE DATE

30. _____ _____
EMPLOYER SIGNATURE DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL
31.

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
Town of Davie

INSURER CODE #
8116

EMPLOYEE'S CLASS CODE

EMPLOYER'S NAICS CODE

SERVICE CO/ TPA CODE #
6239

CLAIMS-HANDLING ENTITY FILE #

CLAIMS-HANDLING ENTITY NAME, ADDRESSS & TELEPHONE
PREF. GOVERNMENTAL CLAIM SOLUTIONS
PO BOX 614004
ORLANDO, FL 32861-4004
TEL: (800) 237-6617
FAX: (321) 832-1448

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

Instructions for Completing State of Florida First Report of Injury

Each box above has been numbered. Please enter the information requested below:

1. Full name of injured employee.
2. Home address of injured employee. **PLEASE DO NOT PUT YOUR WORK ADDRESS.**
3. Personal telephone number where employee is most likely to be contacted (home or cell).
4. Employee's job title and department name, e.g. Homicide Detective, Police Department
5. Employee's date of birth.
6. Sex of employee – Check M or F for male or female.
7. Employee's social security number
8. Date of the accident (month, day & year)
9. Time of accident and am or pm checked off
10. Employee's description of accident with the cause of the injury (very important to be clear & concise about what happened).
11. Injury or Illness description.
12. Describe all parts of the body that were affected by the injury.
13. Employer Address – this is already filled in with Town of Davie and the Town Hall address.
14. Telephone – this is already filled in the with the Risk Management Department phone number.
15. This box should have the Employee's Work Address if different from Town Hall.
16. Address of the Accident Location.
17. Federal Tax ID number – this is already filled in with Town of Davie information.
18. Nature of business – this is already filled in with Town of Davie information.
19. Employee's hire date.
20. Last day employee worked.
21. Check the yes or no box if the employee will return to work and the date if yes.
22. Date of employee's death if applicable.
23. Supervisor to check box yes or no if they agree with the employee's description of the accident.
24. Date injury or illness was first reported (month, day & year).
25. Policy/member number – this is already filled in with Town of Davie information.
26. Check yes or no for whether employee was paid for the date it occurred.
27. Check the yes box if employee will be paid regular wages instead of workers' compensation. Also enter the last day wages will be paid instead of worker's compensation.
28. Rate of employee's pay with number of hours per day, week and number of days per week the employee works.
29. Employee signature and date
30. Employer signature and date
31. Name, address and telephone number of the physician or hospital where the employee was treated and whether or not it was authorized.

Note:

- The remainder of the document will be completed by the insurance carrier.
- If you have any questions, please call Risk Management at 954-797-1097 or 954-797-1110.