

**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 <input type="checkbox"/> AM <input type="checkbox"/> PM
HOME ADDRESS Street/Apt #: _____ City: _____ State: _____ Zip: _____	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 <input type="checkbox"/> M <input type="checkbox"/> F		

**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: _____	DATE EMPLOYED ____/____/____	PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO
LOCATION # (If applicable) _____	LAST DATE EMPLOYEE WORKED ____/____/____	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES
PLACE OF ACCIDENT (Street, City, State, Zip) Street: _____ City: _____ State: _____ Zip: _____	RETURNED TO WORK <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE ____/____/____	LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP ____/____/____
COUNTY OF ACCIDENT _____	DATE OF DEATH (If applicable) ____/____/____	RATE OF PAY \$ _____ PER <input type="checkbox"/> HR <input type="checkbox"/> WK <input type="checkbox"/> DAY <input type="checkbox"/> MO
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. <b>I have reviewed, understand and acknowledge the above statement.</b>	AGREE WITH DESCRIPTION OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	Number of hours per day _____ Number of hours per week _____ Number of days per week _____
EMPLOYEE SIGNATURE (If available to sign) _____ EMPLOYER SIGNATURE _____	DATE _____ DATE _____	NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL  AUTHORIZED BY EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO

**CLAIMS-HANDLING ENTITY INFORMATION**

<input type="checkbox"/> 1(a) Denied Case - DWC-12, Notice of Denial Attached	<input type="checkbox"/> 2. Medical Only which became Lost Time Case (Complete all required information in #3)
<input type="checkbox"/> 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached	Employee's 8 <sup>TH</sup> Day of Disability _____/_____/_____ Entity's Knowledge of 8 <sup>TH</sup> Day of Disability _____/_____/_____ Full Salary in lieu of comp? <input type="checkbox"/> YES Full Salary End Date _____/_____/_____ Date First Payment Mailed _____/_____/_____ AWW _____ Comp Rate _____
<input type="checkbox"/> 3. Lost Time Case - 1st day of disability _____/_____/_____ Penalty Amount Paid in 1 <sup>st</sup> Payment \$ _____ Interest Amount Paid in 1 <sup>st</sup> Payment \$ _____	<input type="checkbox"/> T.T. <input type="checkbox"/> T.T. - 80% <input type="checkbox"/> T.P. <input type="checkbox"/> I.B. <input type="checkbox"/> P.T. <input type="checkbox"/> DEATH <input type="checkbox"/> SETTLEMENT ONLY

REMARKS:	INSURER NAME
INSURER CODE #	EMPLOYEE'S CLASS CODE
SERVICE CO/TPA CODE #	EMPLOYER'S NAICS CODE
CLAIMS-HANDLING ENTITY FILE #	CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

## 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.