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

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 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 ☐ M ☐ F			

EMPLOYER INFORMATION

COMPANY NAME: ____ D. B. A.: ____ Street: ____ City: ____ State: ____ Zip: ____	FEDERAL I.D. NUMBER (FEIN)	DATE FIRST REPORTED (Month/Day/Year)
	NATURE OF BUSINESS	POLICY/MEMBER NUMBER
TELEPHONE Area Code 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 ____ / ____ / ____ RETURNED TO WORK ☐ YES ☐ NO IF YES, GIVE DATE ____ / ____ / ____	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) 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 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** **CLAIMS-HANDLING ENTITY** NAME, ADDRESS & TELEPHONE
INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE	
SERVICE CO/TPA CODE #	**CLAIMS-HANDLING ENTITY** FILE #		

Workers' Compensation Medical Treatment Authorization Form (INJURY)

DIRECTIONS: Complete all Sections A - D Entirely ** ALL services require photo identification to be provided by **(Only services marked on this form will be completed)** **employee at time of service.**

This is authorization to provide medical services to:______________________________ **DOB:**__________ **SSN:**__________

(Print Patient Name Above)

Section A: Employer Information	Section B: Patient Injury Information	Additional Comments/Notes:
Employer Name: Leon County Board of County Commissioners	Injured Body Part(s):	
Address: 301 S. Monroe St. Tallahassee, FL 32301		
Phone #: 850-606-5120	Date of Injury:	
Fax #: 850-606-5103	**Section C: Urine Drug / Alcohol Tests**	
Insurance Carrier	**Urine Drug Screens** ○ Collection Only/Donor will bring COC **Florida Drug Free Workplace** ○ 5 Panel HRS ○ 8 Panel HRS ○ 10 Panel HRS n/a **DOT** ○ DOT/NIDA	
Name: Commercial Risk Management, Inc.		
Address: P.O. Box 18366, Tampa, FL 33679		
Claim: If not available has claim been reported □ yes ■ no		
Fax # 813-289-3771	**Alcohol Testing (LKE, APL, NTH & MHN ONLY)**	
Phone # 813-289-3900 NOI@crm-su.com	○ DOT Breath Alcohol Test ○ Non- DOT Breath Alcohol Test n/a	

Section D: Authorization Information		
Print Name of Authorizer: Shelley L. Cason	Authorizer Signature: *Shelley Cason* Title: Risk Manager	Phone # 850-606-5120 Date:
Fax or Mail results to: 850-606-5103	**Billing Address:** 301 South Monroe St. Suite 201 Tallahassee, FL 32301	**For Patients First Use Only:** Phone Auth received by: Date & Time:

December 7, 2017

Patients First Fax Numbers

Lake Ella -- 850-385-6838	Parkway -- 850-681-2848	North Monroe -- 850-562-4460	
Kerry Forest -- 850-668-3226	Mahan -- 850-656-1391	Appleyard -- 850-576-8153	Raymond Diehl - 850-701-0885