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
	- -		■ AM ☐ PM

HOME ADDRESS

,

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

EMPLOYER/COMPANY

Leon County Board Of County Commissioners
301 South Monroe Street, Suite 201
Tallahassee, FL 32301

TELEPHONE Area Code Number

EMPLOYER'S LOCATION ADDRESS (if different)

Location #:

FEDERAL I.D. NUMBER (FEIN)	DATE FIRST REPORTED (Month-Day-Year)
596000708	
NATURE OF BUSINESS: **Municipality**	POLICY/MEMBER NUMBER: **Self-Insured**
DATE EMPLOYED	PAID FOR DATE OF INJURY ☐ YES ☐ NO
LAST DAY 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?
DATE OF DEATH (If applicable)	RATE OF PAY PER ☐ HR ☐ WK ☐ DAY ☐ MO
AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO	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

Patients First

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

PREF. GOVERNMENTAL CLAIM SOLUTIONS
Claim Services
P.O. Box 614004
Orlando, FL 32861-4004
1-800-237-6617

Updated 2.7.2022

INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE
9566		
SERVICE CO/ TPA CODE #	CLAIMS-HANDLING ENTITY FILE #	
06082		

PATIENTS FIRST
Get in. Get out. Get better.

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: Preferred Governmental Claim Solutions		
Address: Claim Services P.O. Box 614004 Orlando, FL 32861-4004		
Claim: If not available has claim been reported ☐ yes ■ no		
Fax # 1-321-832-1448	**Alcohol Testing (LKE, APL, NTH & MHN ONLY)**	
Phone # 1-800-237-6617	☐ 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
Kerry Forest -- 850-668-3226
Parkway -- 850-681-2848
Mahan -- 850-656-1391
North Monroe -- 850-562-4460
Appleyard -- 850-576-8153
Raymond Diehl - 850-701-0885