ACCIDENT & WORKERS' COMPENSATION CLAIMS

REPORTING PROCEDURES FOR VEHICLE ACCIDENTS

A. Call the appropriate law enforcement agency (when applicable) and the appropriate supervisor. This may be accomplished by radioing to base for assistance or using a standard telephone. Do not leave the accident scene.

B. **Notify** the appropriate supervisor **immediately.**

C. Immediately **notify the Risk Manager** at **606-5120 or 850-284-5669**.

D. Risk Management will notify the carrier of the accident as soon as a Accident or Incident form is completed and submitted, **no later than 24 hours.**

FIRST NOTICE OF INJURY REPORTING

****DO NOT PROVIDE YOUR HEALTH INSURANCE INFORMATION TO ANY MEDICAL FACILITY IF THIS IS A WORKERS' COMPENSATION CLAIM**

A. **Notify** the appropriate supervisor **immediately** following the injury.

B. The supervisor will notify the Risk Manager immediately at **606-5120 or 850-284-5669.**

C. **The First Notice of Injury and Patients First Authorization Forms** must be completed and forwarded to the Risk Manager **within twenty-four (24) hours.**
Email to: casons@leoncountyfl.gov

D. The First Notice of Injury and Patients First Authorization Forms **must identify all body parts that are, or potentially may, be injured, and be specific when identifying areas of pain**.

E. **The First Notice of Injury must be uploaded into the system before additional services can be provided, such as medication, therapies, etc. can be authorized.**

F. The Risk Manager will reach out to the injured volunteer within eight (8) hrs.

G. Do not go to any specialty clinics such as Ortho without prior authorization, Workers' Compensation will not cover these bills.

H. **Any questions, please call Risk Management at 850-606-5120 or 850-284-5669 anytime.**

Employee Assistance Office

The Division of Workers' Compensation, Employee Assistance Office (EAO), helps prevent and resolve disputes between injured workers, employers and carriers. If the insurance carrier does not provide benefits to which you believe you are entitled, you may call EAO's toll-free hotline at **1-800-342-1741**. EAO specialists are knowledgeable about the workers' compensation system. They will be able to address your concerns and attempt to prevent or resolve disputes. EAO has offices throughout the state that you can call or visit. You can find EAO statewide locations at www.MyFloridaCFO.com/Division/WC/Employee/eao_offices.htm.

Services provided by EAO include:

- Educating and providing information to you about your claim.
- Assisting you in resolving disagreements regarding your claim, at no cost to you.
- Assisting you with understanding the procedures for filing a Petition for Benefits with a Judge of Compensation Claims.

Information regarding your rights and responsibilities under the Workers' Compensation Law is available in an on-line "Injured Worker Workshop" presentation on the Division's Web site at www.MyFloridaCFO.com/Division/wc/Employee/education.htm, and answers to frequently asked questions can be accessed at www.MyFloridaCFO.com/Division/wc/Employee/faq.htm.

You may also submit specific questions relating to your claim to us at wceao@MyFloridaCFO.com and receive answers directly by e-mail.

Statute of Limitations

Once you are injured at work or become aware of a workers' compensation injury or illness, you have 30 days in which to report your injury or illness to your employer. Failure to report your injury within 30 days may jeopardize your claim.

Generally, you have two years from the date of your injury or illness to file a claim for workers' compensation benefits. Failure to report your injury or illness within 30 days may be used as a defense against your claim regardless of the two-year statute of limitations for filing a claim. Your eligibility for benefits may also be eliminated one year from the date you last received a wage replacement check or approved medical treatment.

Denial of Benefits

If the insurance carrier does not provide benefits to which you believe you are entitled, or has denied your claim, contact the Employee Assistance Office (EAO). Although the EAO does not provide legal advice, our specialists will answer questions about your rights and responsibilities and may be able to resolve problems you're having with your workers' compensation claim. This help is **free** and available by contacting the EAO at **1-800-342-1741**.

Petition for Benefits

To begin the judicial procedure for obtaining benefits that you believe are due and owing under the law and have not been provided by the employer or insurance carrier, a Petition for Benefits form must be filed with the Office of Judges of Compensation Claims. The form can be accessed at www.jcc.state.fl.us/JCC/forms/.

Reemployment Services

If you are unable to perform the duties required for your former job as a result of your work-related injury or illness, you can contact the Employee Assistance Office (EAO) at WCRES@MyFloridaCFO.com or call **1-800-342-1741** for free reemployment services.

Legal Representation

You are not required to have an attorney. If you do hire an attorney to represent you with your workers' compensation claim, the fees and costs may come out of your benefits, unless your employer or workers' compensation carrier is held responsible for paying your attorney fees. Although the Division does not provide legal advice, the Division will answer questions about your rights and responsibilities and may be able to resolve problems you may have with your workers' compensation claim. This help is **free** and available by contacting the Employee Assistance Office at **1-800-342-1741**.

Anti-Fraud Reward Program

Workers' compensation fraud occurs when any person knowingly and with intent to injure, defraud or deceive any employer or employee, insurance carrier or self-insured program files false or misleading information. Workers' compensation fraud is a third-degree felony that can result in fines, civil liability and jail time. Rewards of up to $25,000 may be paid to individuals who provide information that lead to the arrest and conviction of persons committing insurance fraud. To report suspected workers' compensation fraud, call **1-800-378-0445**.

69L-3.0035, F.A.C. Injured Worker Informational Brochure
Rule 69L-3.025, F.A.C. Forms
DFS-F2-DWC-60
Revised March 2010

EMPLOYEE FACTS

IMPORTANT

WORKERS' COMPENSATION INFORMATION FOR FLORIDA'S WORKERS

DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

If you are injured as a result of a work-related accident, your employer's workers' compensation coverage may entitle you to medical and partial wage replacement benefits.

Medical Benefits

As soon as your employer's workers' compensation insurance company has knowledge of your work-related injury and has determined that your injury or illness is covered under Florida law, the company will:

- Provide an authorized physician
- Pay for all authorized medically necessary care and treatment related to your injury or illness
- Provide a one-time change of physician within five business days of receipt of your written request

Authorized treatment and care may include:

- Doctor visits
- Hospitalization
- Prostheses
- Physical therapy
- Medical tests
- Prescription drugs
- Travel expenses to and from authorized medical treatment or a pharmacy.

Once you reach maximum medical improvement (MMI), you are required to pay a $10 co-payment per visit for medical treatment. MMI occurs when the physician treating you determines that your injury or illness has healed to the extent that further improvement is not likely.

Wage Replacement Benefits

If you are unable to work or your earnings are lower because of a work-related injury or illness, you may be able to receive some wage replacement benefits. You may be eligible for these benefits if you have been disabled for more than seven calendar days and are not able to perform your normal job duties as advised by your authorized doctor.

If you qualify, wage replacement benefits will begin on the eighth day of partial or total disability. You will not receive wage replacement benefits for the first seven days of disability, unless you are disabled for more than 21 days due to your work-related injury or illness.

In most cases, the wage replacement benefits will equal two-thirds of your pre-injury regular weekly wage, but the benefit will not be higher than Florida's average weekly wage. You can generally expect to receive your first benefit check within 21 days after the carrier becomes aware of your injury or illness and bi-weekly thereafter.

- Temporary Total Benefits: These benefits are provided as a result of an injury or illness that temporarily prevents you from returning to work, and you have not reached MMI.
- Temporary Partial Benefits: These benefits are provided when the doctor releases you to return to work with restrictions and you have not reached MMI and earn less than 80 percent of your pre-injury wage. ***Note: The maximum length of time you can receive temporary total or partial benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.***
- Permanent Impairment Benefits: These benefits are provided when the injury or illness causes any physical, psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a whole.
- Permanent Total Benefits: These benefits are provided when the injury causes you to be permanently and totally disabled according to the conditions stated in the law.
- Death Benefits: Compensation for deaths resulting from workplace accidents include payment of funeral expenses and dependency benefits (subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

The rate, amount and duration of compensation for all wage replacement benefits are detailed in the workers' compensation law. **If you have questions about your benefits, call your claims adjuster or the Employee Assistance Office (EAO) at 1-800-342-1741.**

Injured Worker Responsibilities

Communicate with the Employer:

- Contact your employer immediately to notify them of your on-the-job injury or illness.
- Provide your employer a copy of the Medical Treatment/Status Reporting form (DWC25) after each medical appointment.
- Return to work when you are released by your physician and when your employer offers a position within your physical limitations to avoid suspension of your lost wage benefits.

Communicate with the Carrier:

- Review the First Report of Injury or Illness (DWC1) form upon receipt and verify the accuracy of your address, phone number, social security number and the description of the accident. If there is information you do not agree with, or if information has been omitted, immediately notify your adjuster in writing.
- Review, sign and return the mandatory fraud statement to the insurance carrier. By signing this document, you are confirming your understanding of this important information. Your benefits shall be suspended if you refuse to sign this document.
- Report wages from all sources of employment to the carrier if you had more than one employer in the 13 weeks immediately preceding your date of accident. This will assist the carrier in determining the proper wage replacement amount.
- Keep your adjuster regularly informed on the status of your claim, medical authorization needs and any wages you have earned. (Note: If you are represented by an attorney, the adjuster may not be able to speak with you directly.)
- Notify the carrier of any change of address or telephone number.
- Complete and return forms to the carrier when asked.

Communicate with the Authorized Treating Physician:

- Identify all body parts that are, or potentially may, be injured, and be specific when identifying areas of pain.
- Keep your appointments.
- Clarify your work status during appointments before leaving the physician's office.
- Follow your doctor's treatment plan.
- Ask your physician for the patient copy of the Medical Treatment/Status Reporting form (DWC25).
- Notify your physician of any change of address or telephone number.
- Call the authorized treating physician's office if you need to see the doctor before your next appointment date. The doctor's staff may be able to place your name on a cancellation list and you may be scheduled for an earlier appointment should one become available. If an appointment is not available and you need to see a doctor immediately, please contact your adjuster or the EAO.

Carrier Responsibilities

- Timely provision of medical treatment
- Timely payment of wage replacement benefits
- Timely payment of medical bills
- Timely reporting of your claim information to the Division of Workers' Compensation
- Timely notification of any changes in the status of your claim. This information will be provided to you by mail on either a Notice of Action / Change form (DWC4) or a Notice of Denial form (DWC12).

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

NAME (First, Middle, Last)

HOME ADDRESS

Street/Apt #: _____

City: _____ State: _____ Zip: _____

TELEPHONE (AREA CODE) NUMBER ☐ Mobile ☐ Landline

EMAIL ADDRESS

OCCUPATION

DATE OF BIRTH ____ / ____ / ____ SEX ☐ M ☐ F

EMPLOYEE INFORMATION

Social Security Number	Date of Accident (Month-Day-Year)	Time of Accident ☑ AM ☐ PM

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

INJURY/ILLNESS THAT OCCURRED	PART OF BODY AFFECTED

EMPLOYER INFORMATION

COMPANY NAME: Leon County, Florida

D. B. A.: _____

Street: 301 S. Monroe St., Room 201

City: Tallahassee State: FL Zip: 32301

TELEPHONE Area Code Number

EMPLOYER'S LOCATION ADDRESS (If different)

Street: _____

City: _____ State: _____ Zip: _____

LOCATION # (If applicable) _____

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

Street: _____

City: _____ State: _____ Zip: _____

COUNTY OF ACCIDENT _____

FEDERAL I.D. NUMBER (FEIN)
59 6000708

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER
39

DATE EMPLOYED ____ / ____ / ____

PAID FOR DATE OF INJURY ☐ YES ☐ NO

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 ____ / ____ / ____

DATE OF DEATH (If applicable) ____ / ____ / ____

RATE OF PAY ☐ HR ☐ WK
$ _____ PER ☐ 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 CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE
SERVICE CO/TPA CODE #	**CLAIMS-HANDLING ENTITY** FILE #	

INSURER NAME
LEON COUNTY BOCC

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE
COMMERCIAL RISK MANAGEMENT, INC
PO BOX 18366
TAMPA, FL 33679
800/786-6070

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: 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* 12/26/2023 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:

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

If you are injured on the job you should?

1. **REPORT** the accident to your supervisor **immediately**.

2. **If EMERGENCY medical treatment is required, promptly go to the NEAREST medical facility for treatment.**

3. All **OTHER** medical treatment is to be provided by:

PATIENTS FIRST	**PATIENTS FIRST** (OPEN SEVEN DAYS A WEEK)
2907 Kerry Forest Pkwy	**1660 W. Tennessee Street**
850-668-3380	850-359-9307
850-668-3226	850-359-9310
PATIENTS FIRST – (OPEN SEVEN DAYS A WEEK)	**PATIENTS FIRST**
3258 North Monroe (north of I-10)	**1705 E. Mahan Dr. (across from Mary's Drive)**
850-562-2010	850-877-7164
850-562-4460	850-656-1391
PATIENTS FIRST	**PATIENTS FIRST**
505 Appleyard Dr. (across from TCC/Lively)	**3446 Thomasville Road**
850-576-8988	850-386-2266
850-576-8153	850-701-0885
PATIENTS FIRST (OPEN SEVEN DAYS A WEEK)	**PATIENTS FIRST**
LAKE ELLA	**BUCKLAKE**
1690 North Monroe Street	**3652 Mahan Drive**
850-385-2222	850-329-8429
850-385-6838	850-329-8762

If you have **ANY PROBLEMS** or questions about your claim, call **Commercial Risk Management @ 1-813-289-3900 or Risk Management at 606-5120.**

Florida's Workers' Compensation law requires workers to utilize health care providers (doctors and hospitals) who are authorized by their employer. ***Obtaining medical care without authorization may be at your own expense.***

Rev.05/20/2024

LEON COUNTY
ACCIDENT REPORT

Type of accident being reported: (*check all that apply)*
[ ] Vehicle Accident (vehicle-to-vehicle; vehicle-to-property; vehicle damage, other)
[ ] Personal Injury (Workers= Compensation; minor injuries; citizen injury)
[ ] Private Property Damage/General Liability (tire damage; paint damage; property damage)

Following an accident, this accident report is to be completed, signed and forwarded to the appropriate supervisor(s) for comment. Submit the completed report to Risk Management within 24 hours.

Date of Accident:_____ Time of Accident:_____

SECTION 1: EMPLOYEE INFORMATION AND REMARKS

1. County Employee Information (*Use page 2 for additional injury information*)
Name_____ Length of Employment:_____yrs._____months
License type: CDL___ Operator___

2. County Vehicle Information (*if involved in a vehicle accident and/or if County equipment is damaged*)
Tag # _____ Vehicle #_____Vehicle Make_____Model_____ Yr..._____
Use of vehicle at time of accident:_____
Describe vehicle damages: [ ] front [ ] rear [ ] passenger-side [ ] driver-side [ ] windshield [ ] trailer
[ ] mirror(s) [ ] undercarriage [ ] roof [ ] hood [ ] trunk [ ] tailgate [ ] tarp [ ] tire(s) [ ] other
Explain:_____
_____
_____

3. Private/Public Property Information (*may attach Exchange of Information provided by law enforcement*)
Owner of Damaged Property_____
Type and Extent of Damage _____
If applicable, Make of Vehicle _____Model_____Yr._____ Tag #_____
Driver=s Name_____ Drivers License # _____
Address _____Phone #_____

4. Investigation Information
Did local law enforcement investigate?_____ Officer=s Name _____Case Number_____
Highway Patrol _____ Sheriff _____ City Police_____
Were pictures taken? _____ If so, by whom?_____

5. Injury Information (*to the best of your knowledge*)
Name Address Nature/Extent of Injury Employee? or Citizen?
_____
_____
_____
_____
Injured person sent to doctor? Yes [ ] No [ ] Doctor or hospital name: _____

6. Witness Information

Name Address Phone # Employee? or Citizen?

_____

_____

7. Employee statement of how accident occurred (attach sketch, if needed). Provide as much detail as possible the accident; equipment failure, or other extenuating circumstances).

_____

_____

_____ _____

Title County Employee=s Signature Date

SECTION II: FIELD SUPERVISOR REMARKS

1. Describe apparent cause of accident/incident:

_____

_____

_____

Contributing causes:

Unsafe behavior

[ ] violation of policy_____

[ ] improper technique _____

[ ] careless action _____

[ ] other _____

[ ] other_____

Unsafe conditions

[ ] weather condition _____

[ ] road surface _____

[ ] un-level surface _____

[ ] faulty equipment _____

[ ] other_____

2. Was County employee documented at fault by law enforcement for the accident? Yes [ ] No [ ]

Did employee require post-accident drug/alcohol testing as outlined in County policy? **Yes [ ] No [ ]**

If "yes", employee sent for testing within four (4) hours? **Yes [ ] No [ ]** If Ano@, explain:

_____

_____

Was there reasonable suspicion the driver or injured employee was under the influence of drugs and/or alcohol at the time of this accident? Yes [ ] No [ ]

If Ayes@, drug and/or alcohol testing is to be initiated by documenting observable behavior on the Drug/Alcohol Test Reasonable Suspicion Form and the employee is to be escorted to the appropriate facility for testing.

Was there a death as a result of this accident? Yes [ ] No [ ]

If Ayes@, drug and alcohol testing is required, regardless of who was at fault.

3. What steps were taken after the accident/incident to ensure the safety of others? _____

_____

_____

_____ _____

Field Supervisor Signature Date

SECTION III: PROGRAM SUPERVISOR or DEPARTMENT HEAD REMARKS

1. Corrective Action(s) and/or Recommendation).

_____

_____

_____ _____

Program Supervisor Signature Date

SECTION IV: SAFETY COMMITTEE REMARKS

Safety Committee Comments/Recommendation:

[ ] Safety Committee agrees with program supervisor=s corrective action(s) and/or recommendations.

[ ] Safety Committee does not agree with program supervisor=s corrective action(s) and/or recommendations.

Comments: _____

_____

_____

_____ _____

Safety Committee Representative Date

Division/Department Final Action (if applicable)

Procedure/Policy Change:

_____

Disciplinary Action:

_____

Concur with Accident Review Board (when applicable) **Yes [ ]** **No[ ]**

_____ _____

Division/Department Signature Date

General Accident/Incident Report

REPORTED BY: _____ **DATE OF REPORT:** _____ **TIME:** _____

Phone number: _____ **Address:** _____

INCIDENT INFORMATION

INCIDENT TYPE: _____ **DATE OF INCIDENT:** _____

LOCATION: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

SPECIFIC AREA OF LOCATION ***(if applicable):*** _____

INCIDENT DESCRIPTION

NAME / ROLE / CONTACT OF PARTIES INVOLVED/CONTACT INFORMATION OF WITNESSES

1. _____

2. _____

3. _____

SENT TO THE DOCTOR: ( ) Yes ( ) No Describe Injury: _____

DESCRIBE APPARENT CAUSE OF ACCIDENT/INCIDENT:

_____

_____

WHAT STEPS WERE TAKE AFTER THE ACCIDENT/INCIDENT TO SURE THE SAFETY OF OTHERS

_____

_____

NOTES/FOLLOW-UP ACTION

NAME: _____ **SIGNATURE:** _____ **DATE:** _____