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

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

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

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