

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		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 checked="" type="checkbox"/> F			

EMPLOYER INFORMATION

EMPLOYER/COMPANY Monroe County Board Of County Commissioners 1100 Simonton Street, Room 2-274, Gato Building Key West, FL 33040		FEDERAL I.D. NUMBER (FEIN) 59-6000-749	DATE FIRST REPORTED (Month-Day-Year)
TELEPHONE		NATURE OF BUSINESS Municipality	POLICY/MEMBER NUMBER Self-insured
(305) 292-4449		DATE EMPLOYED	PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER'S LOCATION ADDRESS (if different)		LAST DAY EMPLOYEE WORKED	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES
Location #:		RETURNED TO WORK? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE	LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP?
PLACE OF ACCIDENT (Street, City, State, Zip)		DATE OF DEATH (if applicable)	RATE OF PAY
COUNTY: Monroe		AGREE WITH DESCRIPTION OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PER <input type="checkbox"/> HR <input type="checkbox"/> WK <input type="checkbox"/> DAY <input type="checkbox"/> 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.			NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL
EMPLOYEE SIGNATURE (If available to sign)		DATE	AUTHORIZED BY EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER SIGNATURE		DATE	

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) Employee's 8th Day Of Disability Entity's Knowledge of 8th Day of Disability
<input type="checkbox"/> 1(b) Indemnity Only Denied Case – DWC-12, Notice Of Denial Attached	Full Salary in lieu of comp? <input type="checkbox"/> YES Full Salary End Date
<input type="checkbox"/> 3. Lost Time Case – 1st day of disability	
Date First Payment Mailed	AWW
<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	Comp Rate
Penalty Amount Paid in 1st Payment	Interest Amount Paid in 1st Payment

REMARKS:			INSURER NAME Monroe County Board of County Commissioners
INSURER CODE # 9345	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE	CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE PREF. GOVERNMENTAL CLAIM SOLUTIONS PO BOX 958456 LAKE MARY, FL 32795-8456 TEL: (800) 237-6617 FAX: (321) 832-1448
SERVICE CO/ TPA CODE # 06082	CLAIMS-HANDLING ENTITY FILE #		