FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPT. OF LABOR & EMPLOYMENT SECURITY
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-Hndling 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 FL. Zip _____

TELEPHONE Area Code Number

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

OCCUPATION

DATE OF BIRTH _____ / _____ / _____

SEX ☑ M ☐ F

INJURY / ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

EMPLOYER INFORMATION

COMPANY NAME: CITY OF PUNTA GORDA

D.B.A.: SAME

Street: 326 WEST MARION AVENUE

City: PUNTA GORDA State FL Zip 33950

TELEPHONE Area Code 941 Number 575-3303

FEDERAL I.D. NUMBER (FEIN): 59-6000415

NATURE OF BUSINESS: MUNICIPAL GOVERNMENT

DATE EMPLOYED _____ / _____ / _____

DATE FIRST REPORTED (Mo/Day/Yr) _____ / _____ / _____

POLICY/MEMBER NUMBER: PK2FL1 0082001 15-01

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' COMPENSATION? ☐ YES

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMPENSATION. _____ / _____ / _____

RATE OF PAY ☐ HR ☐ WK

$ _____ PER ☐ DAY ☐ MO

Number of hours per day _____

Number of hours per week _____

Number of days per week _____

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

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 continued 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

Penaly Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

REMARKS:

WORKERS COMP. BROCHURE GIVEN TO EMPLOYEE YES ☐ NO ☐

INSURER CODE #	EMPLOYEE'S RISK CLASS CODE	EMPLOYER'S NAICS CODE

SERVICE CP/TPA CODE # **6008**

CLAIMS-HANDLING ENTITY FILE #

INSURER NAME
SELF-INSURED THROUGH PUBLIC RISK MANAGEMENT OF FLORIDA

CLAIMS-HANDLING ENTITY NAME, ADDRESS, & TELEPHONE
GALLAGHER BASSETT SERVICES, INC.
P.O. BOX 1880
FT. MYERS, FL 33902-1880
TELEPHONE: 1-800-541-3322