

# FIRST REPORT OF INJURY OR ILLNESS

## 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 1-850-922-8953

RECEIVED BY CARRIER	SENT TO DIVISION	DIVISION REC'D 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 Street/Apt. #: _____ City: _____ State: _____ Zip: _____		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 type="checkbox"/> F			

### EMPLOYER INFORMATION

COMPANY NAME: _____	FEDERAL I.D. NUMBER (FEIN)	DATE FIRST REPORTED (Month/Day/Year)
D.B.A.: _____	NATURE OF BUSINESS	POLICY/MEMBER NUMBER
Street: _____		
City: _____ State: _____ Zip: _____	DATE EMPLOYED _____ PA _____	ID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO
TELEPHONE Area Code _____ Number _____	DATE EMPLOYED _____ PA _____	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKER'S COMP? <input type="checkbox"/> YES
EMPLOYER'S LOCATION ADDRESS (If different) Street: _____	LAST DATE EMPLOYEE WORKED	LAST DAY WAGES WILL BE PAID INSTEAD OF WORKER'S COMP
City: _____ State: _____ Zip: _____	RETURNED TO WORK <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE _____	RATE OF PAY <input type="checkbox"/> HR <input type="checkbox"/> WK \$ _____ PER <input type="checkbox"/> DAY <input type="checkbox"/> MO
LOCATION # (If applicable)	DATE OF DEATH (If applicable)	Number of hours per day _____
PLACE OF ACCIDENT (Street, City, State, Zip) Street: _____	AGREE WITH DESCRIPTION OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	Number of hours per week _____
City: _____	NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL	Number of days per week _____
COUNTY OF ACCIDENT: _____		AUTHORIZED BY EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO
<p><b>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 mis-leading information is guilty of a felony of the third degree. I have reviewed, understand and acknowledge the above statement.</b></p>		
EMPLOYEE SIGNATURE (If available to sign) _____	DATE _____	
EMPLOYER SIGNATURE _____	DATE _____	

### CARRIER INFORMATION

<input type="checkbox"/> <b>1.</b> Case Denied--DWC-12, Notice of Denial Attached		<input type="checkbox"/> <b>2.</b> Medical Only which became Lost Time Case (Complete all info in #3)	
<input type="checkbox"/> <b>3.</b> Lost Time Case -- 1st day of disability ____/____/____ Salary continued in lieu of comp? <input type="checkbox"/> YES Salary End Date ____/____/____ Date First Payment Mailed ____/____/____ AWW _____ Comp Rate _____ <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			
REMARKS: _____			
CARRIER CODE #			CARRIER NAME, ADDRESS & TELEPHONE
EMPLOYEE'S RISK CLASS CODE		EMPLOYER'S SIC CODE	
SERVICE CO/TPA CODE #		CARRIER FILE #	
is employer self-insured? YES NO			