Please complete all highlighted fields

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

For assistance call [redacted]
or contact your local FAO Office
Insurance & Risk Management Office at 727-374-0222

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 ☐ AM ☐ PM

HOME ADDRESS
Street/Apt #: _____
City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

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

OCCUPATION

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

DATE OF BIRTH
_____ / _____ / _____

SEX ☐ M ☐ F

EMPLOYER INFORMATION

COMPANY NAME: Diocese of St Petersburg
D. B. A.: _____
Street: _____
City: St Petersburg State: Florida Zip: 33710

TELEPHONE Area Code Number
727-374-0222

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

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 ☐ DAY ☐ MO
$ _____ PER
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

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 NAME

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

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

SERVICE CO/TPA CODE # | **CLAIMS-HANDLING ENTITY** FILE #

Form DFS-F2-DWC-1 (10/2016) Rule 69L-3.025, F.A.C.

ONCE FORM IS COMPLETED:
- Email completed form to Commercial Risk Management at NOI@crm-su.com
- Notify the DOSP Insurance & Risk Management Office by emailing form to VCB@@DOSP.ORG or fax 727-374-0214