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 CLAIM-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	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) CONTACT WITH SHARP OBJECTS		
Occupation: Date of Birth / Sex ☐M ☐F	Injury/Illness That Occurred HEART DISORDER	Part of Body Affected (Select Body Part Description) (Select Body Part Description) (Select Body Part Description)	

EMPLOYER INFORMATION

Co. Name: CITY OF HOLLYWOOD, FL D.B.A.: Street: 2600 HOLLYWOOD BLVD #206 City: Hollywood State: FL Zip 33020	Federal ID Number (FEIN) 596000338 Nature of Business Municipality	Date First Reported (Month/Day/Year) Policy/Member Number SELF INSURED
Telephone: Area Code Number	Date Employed	Paid for Date of Injury ☐Yes ☐No
Employer's Location Address (if different) Street: City: State: Zip:	Last Date Employee Worked Returned to Work ☐No If Yes, Give Date ☐Yes	Will you continue to pay wages instead of Workers' Comp? ☐Yes Last day wages will be paid instead of Worker's Comp. ____/____/____ Rate Of Pay $_____ Per ☐HR ☐WK ☐DAY ☐MO
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	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 Florida Statute 817.234. Section 440.105(7), F.S.

Employee Signature (if available) _____ Date _____

Employer Signature _____ Date _____

Name, Address Telephone and Fax of Physician or Hospital

Authorized by Employer ☐Yes ☐No

CLAIMS-HANDLING ENTITY INFORMATION

1a.☐ Case Denied - DWC-12, Notice of Denial Attached
1b.☐ Indemnity Only Denied Case - DWC-12, Notice of Denial Attached
2. ☐ Medical Only which became Lost Time Case (Complete all info 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 : **City of Hollywood**
Claims-Handling Entity Name, Address & Telephone
Relation Insurance Services
700 Central Parkw
Stuart, FL 34994
1-800-431-2221

INSURER CODE #	Employee's Class Code	Employer's NAICS Code
9633		921190
Service Co/TPA Code # 6060	Claims-Handling Entity File #	

Form DFS-F2-DWC-1 (03/2009) Rule 69L-3.025, F.A.C.

ADDITIONAL NOTES:

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records request and subpoenas that require production of specified documents. The social security number may also be used for any other specifically required or authorized by state or federal law.