SELF-INSURANCE
UNIT STATISTICAL REPORT

REPORT NO.
1 [ ] 2 [ ] 3 [ ]

EMPLOYER NUMBER	ACCOUNT NUMBER	BEGINNING DATE	ENDING DATE

EMPLOYER NAME (s)

CLAIM NUMBER OR NUMBER OF CLAIMS	STATUS	INJURY CODE	PAYROLL CLASS CODE	DATE OF ACCIDENT (EXCESS CLAIMS ONLY)	INCURRED LOSS	
					MEDICAL	INDEMNITY

TOTALS _____

ENTER BELOW TOTAL ALLOCATED LOSS ADJUSTMENT EXPENSE INCURRED

_____

REPORT COMPLETED BY:

_____

PLEASE RETURN COMPLETED REPORT TO:
Division of Workers' Compensation
Bureau of Monitoring & Audit
SELF-INSURANCE SECTION
200 E. Gaines St.
TALLAHASSEE, FL 32399-4224

FORM SI-17 (1/2008)j:\siforms\wwm\si-17