EMPLOYEE EARNINGS REPORT

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

CLAIMS-HANDLING ENTITY RECEIVED DATE	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

CAUTION

FAILURE OR REFUSAL OF EMPLOYEE TO COMPLETE, SIGN, AND RETURN THIS REPORT WITHIN 21 DAYS AFTER THE DATE OF RECEIPT OF THE REQUEST MAY CAUSE PAYMENT OF BENEFITS TO STOP UNTIL SUCH TIME AS THE COMPLETED FORM IS FURNISHED TO THE REQUESTING PARTY.

PLEASE PRINT OR TYPE

I. IDENTIFICATION OF PARTIES (To be completed by requesting party)

EMPLOYEE'S SOCIAL SECURITY NUMBER [redacted]	EMPLOYEE'S NAME (First, Middle, Last)	DATE OF ACCIDENT: (Month-Day-Year)
EMPLOYEE'S ADDRESS	ACCIDENT EMPLOYER'S NAME & ADDRESS	CLAIMS-HANDLING ENTITY NAME & ADDRESS

II. NOTICE TO EMPLOYEE

THE WORKERS' COMPENSATION LAW REQUIRES ALL PERSONS RECEIVING OR CLAIMING BENEFITS FOR TEMPORARY DISABILITY AND/OR PERMANENT TOTAL DISABILITY TO REPORT ALL EARNINGS OF ANY NATURE TO THE EMPLOYER, INSURANCE COMPANY AND/OR DIVISION OF WORKERS' COMPENSATION. PLEASE COMPLETE THIS REPORT AND RETURN IT TO THE REQUESTING PARTY WITHIN 21 DAYS AFTER THE DATE OF YOUR RECEIPT.

TIME PERIOD TO BE REPORTED **FROM**	**TO**	HAVE YOU RECEIVED INCOME FROM ANY SOURCE OTHER THAN WORKERS' COMPENSATION?
		☐ YES (IF YES, COMPLETE FORM, SIGN, DATE, & RETURN) ☐ NO (IF NO, SIGN, DATE AND RETURN)

IF NECESSARY, ATTACH ADDITIONAL EARNINGS DOCUMENTATION

III. HAVE YOU RECEIVED EARNINGS FROM ANY PERSON, FIRM OR COMPANY DURING THE TIME PERIOD IN SECTION II? ☐ YES (IF YES, COMPLETE INFORMATION BELOW) ☐ NO

PERSON/FIRM/COMPANY NAME	ADDRESS	PERIOD WORKED FROM	PERIOD WORKED TO	TOTAL GROSS EARNINGS

IV. DURING THE TIME PERIOD IN SECTION II, HAVE YOU BEEN SELF-EMPLOYED? ☐ YES ☐ NO

BRIEFLY DESCRIBE NATURE OF BUSINESS OR SERVICE

DATES SELF-EMPLOYED FROM	DATES SELF-EMPLOYED TO	WAGES, INCOME OR BENEFITS RECEIVED	DATES SELF-EMPLOYED FROM	DATES SELF-EMPLOYED TO	WAGES, INCOME OR BENEFITS RECEIVED

V. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED ANY SOCIAL SECURITY BENEFITS? ☐ YES (IF YES, STATE AMOUNTS) ☐ NO

TOTAL MONTHLY SOCIAL SECURITY INCOME	AMOUNT PAID FOR YOUR DISABILITY	AMOUNT PAID FOR YOUR DEPENDENTS

VI. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED WAGES, INCOME, OR BENEFITS FROM ANY OTHER SOURCE, i.e. Unemployment Compensation Benefits, Workers' Compensation Benefits from another insurer, etc? Attach additional documentation if necessary. ☐ YES (IF YES, STATE AMOUNTS) ☐ NO

SOURCE OF WAGES, INCOME OR BENEFITS	**PERIOD BENEFITS RECEIVED** FROM	TO	TOTAL AMOUNT

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. THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE'S SIGNATURE _____ DATE _____

VII. RETURN TO (To be completed by requesting party):

REQUESTING PARTY'S NAME	REQUESTING PARTY'S SIGNATURE	REQUESTING PARTY'S ADDRESS & TELEPHONE
TITLE	DATE: (Month-Day-Year)	

DWC-19 Purpose and Use Statement

The collection of the social security number on this form is imperative for the Division of Workers' Compensation's performance of its duties and responsibilities as prescribed by law. 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 requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.