FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

REQUEST FOR WAGE LOSS/TEMPORARY PARTIAL BENEFITS

1-800-342-1741 or contact your local office for assistance

COMPLETE ALL APPLICABLE SECTIONS BEFORE FILING WITH THE DIVISION

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

EMPLOYEE NAME (First, Middle, Last) & ADDRESS	EMPLOYER NAME & ADDRESS	SOCIAL SECURITY #
TELEPHONE:	TELEPHONE:	DATE OF ACCIDENT: (Month-Day-Year)

EMPLOYEE: You must complete one of these forms every two weeks. Complete and sign this section and submit to the claims-handling entity (adjuster) handling your claim.

ARE YOU RECEIVING SOCIAL SECURITY? ☐ YES ☐ NO IF YES, AMOUNT $ ____________________

ARE YOU RECEIVING UNEMPLOYMENT COMPENSATION? ☐ YES ☐ NO IF YES, AMOUNT $ ____________________

I CLAIM LOSS OF WAGES FOR TWO WEEKS AS FOLLOW Week One _____/_____/_____ Week Two _____/_____/_____

☐ I WAS EMPLOYED DURING THIS TWO WEEK PERIOD AS FOLLOWS: (Attach check stub or other documentation.)

EMPLOYER NAME & ADDRESS

____

EMPLOYER TELEPHONE (_____) ____

Gross Wages: Week One $ ____________________ Week Two $ ____________________

☐ I WAS NOT EMPLOYED AND LOOKED FOR EMPLOYMENT AS DOCUMENTED ON THE BACK OF THIS FORM.

Upon making this claim and signing this document, I hereby authorize the release of Unemployment Compensation wage and benefit information and I hereby authorize the release of Social Security information. I declare that the facts reported herein are true to the best of my knowledge and I understand that any false or misleading statement I make could subject me to prosecution for fraud pursuant to Section 440.1051(3), Florida Statutes.

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.

EMPLOYEE SIGNATURE ____ DATE ____

CLAIMS-HANDLING ENTITY: Compute wage loss and complete other areas. Send employee copy with payment check and additional forms. Forward copy to employer (at time of injury) and to Division (upon request).

☐ WAGE LOSS: MMI Date _____/_____/_____ Rating __________% ☐ TEMPORARY PARTIAL ☐ CONTROVERTED - DWC-12 Attached

WEEKS ONE: _____/_____/_____ to _____/_____/_____		WEEK TWO: _____/_____/_____ to _____/_____/_____	
AWW-BEFORE INJURY (Use applicable rate) _________ x _________	ADJ. WW	AWW-BEFORE INJURY (Use applicable rate) _________ x _________	ADJ. WW
TOTAL GROSS EARNINGS Discount Factor Applied? ☐ Yes ☐ No Deemed earnings ☐ Yes ☐ No	-	TOTAL GROSS EARNINGS Discount Factor Applied? ☐ Yes ☐ No Deemed earnings ☐ Yes ☐ No	-
TOTAL WAGE LOSS	=	TOTAL WAGE LOSS	=
MULTIPLY BY APPLICABLE RATE	x	MULTIPLY BY APPLICABLE RATE	x
WAGE LOSS BENEFITS	=	WAGE LOSS BENEFITS	=
OFFSET (Identify benefits)	-	OFFSET (Identify benefits)	-
AMOUNT DUE/PAID	=	AMOUNT DUE/PAID	=

TOTAL AMOUNT PAID $ ____________________ Date _____/_____/_____

ADJUSTER NAME: DATE: _____/_____/_____	INSURER NAME: CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE:
ADJUSTER SIGNATURE:	

Form DFS-F2-DWC-3 (03/2009) Rule 69L-3.025, F.A.C.

NAME

SOCIAL SECURITY NUMBER
✂

WORK SEARCH REPORT

DURING THE TWO-WEEK PERIOD CLAIMED, I HAVE ATTEMPTED TO FIND EMPLOYMENT WITHIN MY PHYSICAL AND VOCATIONAL CAPABILITIES AT EACH BUSINESS, EMPLOYMENT AGENCY AND JOB SERVICE OF FLORIDA LOCATION LISTED BELOW.

DATE	JOB APPLIED FOR	CONTACT PERSON	NAME, ADDRESS AND TELEPHONE NUMBER OF COMPANY	APPLICATION FILED	RESULT OF CONTACT
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	

DWC-3 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.