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 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

DATE OF BIRTH / /

SEX ☐ M ☐ F

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

EMPLOYER INFORMATION

COMPANY NAME:

D. B. A.:

Street:

City: State: Zip:

TELEPHONE Area Code ( ) Number

EMPLOYER'S LOCATION ADDRESS (If different)

Street:

City: State: Zip:

LOCATION # (If applicable)

PLACE OF ACCIDENT (Street, City, State, Zip)

Street:

City: State: Zip:

COUNTY OF ACCIDENT

FEDERAL I.D. NUMBER (FEIN)

NATURE OF BUSINESS

DATE EMPLOYED ____ / ____ / ____

LAST DATE EMPLOYEE WORKED ____ / ____ / ____

RETURNED TO WORK ☐ YES ☐ NO
IF YES, GIVE DATE ____ / ____ / ____

DATE OF DEATH (If applicable) ____ / ____ / ____

AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO

DATE FIRST REPORTED (Month/Day/Year)

POLICY/MEMBER NUMBER

PAID FOR DATE OF INJURY ☐ YES ☐ NO

WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP ____ / ____ / ____

RATE OF PAY ☐ HR ☐ WK

$ PER ☐ DAY ☐ MO

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 CODE #

EMPLOYEE'S CLASS CODE

EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE #

CLAIMS-HANDLING ENTITY FILE #

INSURER NAME
FL DFS, DIV OF RISK MANAGEMENT

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE
STATE OF FLORIDA
DEPT OF FINANCIAL SERVICES, DIV. OF RISK MANAGEMENT
PO BOX 8020
TALLAHASSEE FL 32314-8020
(850) 413-3123

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1

BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3

NOTE: Health care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.

1. Insurer Name:	2. Visit/Review Date:	FOR INSURER USE ONLY
3. Injured Employee (Patient) Name:	4. Date of Birth:	5. Social Security #:
6. Date of Accident:	7. Employer Name	8. Initial visit with this physician? ☐ a) NO ☐ b) YES

SECTION I CLINICAL ASSESSMENT / DETERMINATIONS

9. ☐ No change in Items 9 - 13d since last reported visit. If checked, GO TO SECTION II.

10. Injury/ Illness for which treatment is sought is:
☐ a) NOT WORK RELATED ☐ b) WORK RELATED ☐ c) UNDETERMINED as of this date

11. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable.
☐ a) NO ☐ b) YES ☐ c) UNDETERMINED as of this date
If YES or UNDETERMINED, explain: _____

12. Diagnosis(es): _____

13. Major Contributing Cause: When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 11.
a) Is there a pre-existing condition contributing to the current medical disorder?
☐ a_1) NO ☐ a_2) YES ☐ a_3) UNDETERMINED as of this date
b) Do the objective relevant medical findings identified in Item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition?
☐ b_1) NO ☐ b_2) exacerbation ☐ b_3) aggravation ☐ b_4) UNDETERMINED as of this date
c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?
☐ c_1) NO ☐ c_2) YES
d) Given your responses to the Items above, is the injury/illness in question the major contributing cause for:
☐ d_1) NO ☐ d_2) YES the reported medical condition?
☐ d_3) NO ☐ d_4) YES the treatment recommended (management/treatment plan)?
☐ d_5) NO ☐ d_6) YES the functional limitations and restrictions determined?

SECTION II PATIENT CLASSIFICATION LEVEL

☐ 14. LEVEL I - Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment correlates to the specific findings.

☐ 15. LEVEL II - Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance, and motor control. Treatment: physical reconditioning and functional restoration.

☐ 16. LEVEL III - Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.

☐ 17. LEVEL UNDETERMINED AS OF THIS DATE.

SECTION III MANAGEMENT / TREATMENT PLAN

☐ 18. No clinical services indicated at this time. If checked, GO TO SECTION IV

☐ 19. No change in Items 20a - 20g since last report submitted. If checked, GO TO SECTION IV

20. The following proposed, subsequent clinical service(s) is/are deemed medically necessary.
*** THIS IS A PROVIDER'S WRITTEN REQUEST FOR INSURER AUTHORIZATION OF TREATMENT OR SERVICES. ***

☐ a) Consultation with or referral to a specialist. Identify principal physician: _____
Identify specialty & provide rationale: _____
☐ a_1) CONSULT ONLY ☐ a_2) REFERRAL & CO-MANAGE ☐ a_3) TRANSFER CARE

☐ b) Diagnostic Testing: (Specify) _____

☐ c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:
☐ c_1) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.
☐ c_2) Physical Reconditioning (Level II Patient Classification)
☐ c_3) Interdisciplinary Rehabilitation Program (Level III Patient Classification)
Specific instruction(s): _____

☐ d) Pharmaceutical(s) (specify): _____

☐ e) DME or Medical Supplies: _____

☐ f) Surgical Intervention - specify procedure(s): _____
☐ f_1) In-Office: _____
☐ f_2) Surgical Facility: _____
☐ f_3) Injectable(s) (e.g. pain management): _____

☐ g) Attendant Care: _____

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 2

Patient Name: **Soc.Sec.#:** **D/A:** **Visit/Review Date:**

SECTION IV FUNCTIONAL LIMITATIONS AND RESTRICTIONS

Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status related to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.

☐ **21** **No functional limitations identified or restrictions prescribed as of the following date:** _____.

☐ **22.** **The injured workers' functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of the following date:** _____. ***Use additional sheet if needed.***

☐ **23.** **The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient. Identify joint and/or body part** _____. **Use additional sheet if needed.**

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
☐ Bend			
☐ Carry			
☐ Climb			
☐ Grasp			
☐ Kneel			
☐ Lift-floor > waist			
☐ Lift-waist>overhead			
☐ Pull			
☐ Push			
☐ Reach-overhead			
☐ Sit			
☐ Squat			
☐ Stand			
☐ Twist			
☐ Walk			
☐ _			
☐ Other			

COMMENTS:

Other choices; Skin Contact/ Exposure; Sensory; Hand Dexterity; Cognitive; Crawl; Vision; Drive/Operate Heavy Equipment; Environmental Conditions: heat, cold, working at heights, vibration; Auditory; Specific Job Task(s); etc.

NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date.

Specify those functional limitations and restrictions, in Item 23, which are permanent if MMI / PIR have been assigned in Item 24.

SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING

24. **Patient has achieved maximum medical improvement?**

☐ **a) YES, Date:** _____ ☐ **b) NO** ☐ **c) Anticipated MMI date:** _____

☐ **d) Anticipated MMI date cannot be determined at this time.** **Future Medical Care Anticipated: e)** ☐ **Yes f)** ☐ **No**

Comments: _____

25. _____ **% Permanent Impairment Rating** (body as a whole) **Body part/system:** _____

26. **Guide used for calculation of Permanent Impairment Rating (based on date of accident - see instructions):**

☐ **a) 1996 FL Uniform PIR Schedule** ☐ **b) Other, specify** _____

27. **Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?**

☐ **a) YES** ☐ **b) NO** ☐ **c) Undetermined at this time.**

SECTION VI FOLLOW-UP

28. **Next Scheduled Appointment Date & Time:** _____

SECTION VII ATTESTATION STATEMENT

"As the Physician, I hereby attest that all responses herein have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation this patient, and have been shared with the patient." *" I certify to any MMI / PIR information provided in this form."*

Physician Group: _____ **Date:** _____

Physician Signature: _____ **Physician DOH License #:** _____

Physician Name: _____ **Physician Specialty:** _____

(print name)

If any direct billable services for this visit were rendered by a provider other than a physician, please complete sections below:

"I hereby attest that all responses herein relating to services I rendered have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical regarding documentation regarding this patient, and have been shared with the patient."

Provider Signature: _____ **Provider DOH License #:** _____

Provider Name: _____ **Date:** _____

(print name)

WAGE STATEMENT

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

RECEIVED BY CLAIMS-HANDLING ENITY

NOTICE TO EMPLOYEE: If you have any questions about the information contained on this form, please contact your employer or claim-handling entity. If further assistance is needed, contact the Division's Employee Assistance Office at 1-800-342-1741.

PLEASE PRINT OR TYPE

	EMPLOYEE NAME (First, Middle, Last)	DATE OF ACCIDENT (Month-Day-Year)
EMPLOYER NAME & ADDRESS	CONCURRENT EMPLOYER NAME & ADDRESS (If applicable)	ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE? _____ YES _____ NO
		SIMILAR EMPLOYEE'S NAME
TELEPHONE	TELEPHONE	OCCUPATION OF SIMILAR EMPLOYEE

EMPLOYEE'S CUSTOMARY WORK WEEK	EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK	EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK	EMPLOYER'S CUSTOMARY WORK WEEK
(ex. Saturday thru Friday - Use 7 calendar day period)	(ex. 5 days / week)	(ex. 40 hours / week)	(ex. Saturday thru Friday - Use 7 calendar day period)

NOTICE TO EMPLOYER: Please read all instructions on the back of this form carefully. Complete the form as fully as possible and submit it to your claims-handling entity within 14 days after knowledge of any accident that has caused your employee to be disabled for more than 7 calendar days. If you discontinue providing any fringe benefits, you must file a corrected Wage Statement with your claims-handling entity within 7 days of such termination, reflecting the type and amount of fringe benefits that were paid, and the last date they were provided.

Please list wages earned for the 13 calendar weeks (Sunday through Saturday) immediately preceding the accident.

Do Not Report Any Wages Earned During The Week of the Accident – Use The 13 Calendar Weeks Immediately Preceding The Accident

WEEK NO.	WEEK FROM	WEEK TO	# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK	GROSS PAY	GRATUITIES AS REPORTED TO THE EMPLOYER IN WRITING AS TAXABLE INCOME	FRINGE BENEFITS (employee rec'd) EMPLOYER COST ONLY: HEALTH INSURANCE	FRINGE BENEFITS (employee rec'd) EMPLOYER COST ONLY: RENT/ HOUSING
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
* *								
TOTAL								

RETURN THIS FORM TO:
(Claims-handling entity Name, Address & Telephone #)

P.O. Box 8020
Tallahassee, FL 32314-8020
(850) 413-3123

CLAIM NO.:

WILL EMPLOYER CONTINUE TO PROVIDE ABOVE BENEFITS?	
_____YES_____NO	_____YES_____NO
TOTAL FRINGE BENEFITS	$
TOTAL OF GROSS PAY, GRATUITIES AND FRINGES	$

(FOR CLAIMS-HANDLING ENTITY USE ONLY)

AWW	COMP RATE

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.

PREPARER'S NAME _____ TELEPHONE # _____ DATE _____

WAGE STATEMENT REPORTING INSTRUCTIONS

General: Florida law requires disabled employees to be compensated at a certain percentage of their average weekly wage. If the injured employee worked during "substantially the whole of 13 calendar weeks" immediately preceding the accident, the employee's average weekly wage is one-thirteenth of the total amount of wages earned during the 13 calendar weeks. The term "substantially the whole of 13 calendar weeks" means not less than 75% of the total customary full-time hours of employment during that period.

NOTICE TO EMPLOYER: Please read all instructions on this form carefully. Complete the form as fully as possible and submit it to your claims-handling entity within 14 days after your knowledge of any accident that has caused your employee to be disabled for more than 7 calendar days. If you discontinue providing any fringe benefits, you must file a corrected Form DWC-1a (Wage Statement) with your claims-handling entity within 7 days of such termination, reflecting the type and amount of fringe benefits that were paid, and the last date they were provided.

- **DO NOT combine wages of two or more employees.**
- **Calendar Week:** means a seven-day period of time, which starts on Sunday and continues through Saturday.

Week of Accident – **DO NOT** report any wages earned during the week of the accident. Use the 13 calendar weeks immediately preceding the week of the accident and start with the most recent full calendar week before the week of the accident. For example, if the accident occurred on a Wednesday, then week No. 1 should begin the preceding Sunday and end the preceding Saturday.

Reporting Gross Pay: Complete **all** columns as applicable. Report the actual **gross** earnings of the injured employee for the consecutive 13 calendar week period immediately preceding the accident. The 13 calendar week period includes Saturdays, Sundays, holidays, and other non-working days. Remember to include all overtime and any bonuses paid during the 13 calendar week period. If the injured employee was not employed for you for approximately 68 days during that period, enter the wages of a similar employee in the same employment who was employed for approximately 68 days of the 13 calendar week period. **DO NOT** combine wages for two or more employees to yield wages for the 13 calendar weeks. The spaces immediately following week #13 are to be used for reporting the wages earned in a partial week when requested.

Reporting Gratuities & Fringe Benefits: Gratuities reported should include only those gratuities reported to the employer in writing as taxable income received in the course of employment from others than the employer. The reportable value of a fringe benefit is the actual cost to the employer for the benefit furnished. The only fringe benefits that can be included for dates of accident occurring on or after 07/01/1990 are employer contributions for health insurance for the employee or the employee's dependents, and the reasonable value of housing furnished to the employee by the employer which is intended as the permanent year-round housing of the employee.

If you have questions or need assistance in the completion of this required form, please contact the claims-handling entity listed on the front of this form.

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS
OFFICE OF THE JUDGES OF COMPENSATION CLAIMS

PETITION FOR WORKERS' COMPENSATION BENEFITS

Employee/Claimant petitions the Office of the Judges of Compensation Claims for an order requiring Employer/Carrier to provide benefits due under Chapter 440, Florida Statutes as claimed below.

EMPLOYEE: **ADDRESS:** **TELEPHONE:**	**OJCC CASE NO.** (required if previously issued): **or, EMPLOYEE'S SOCIAL SECURITY NO.:** **or attach a VERIFIED MOTION FOR SUBSTITUTE IDENTIFICATION NUMBER** (form available on the OJCC website at www.jcc.state.fl.us)
EMPLOYER: **ADDRESS:** **TELEPHONE:**	**CARRIER:** **ADDRESS:** **TELEPHONE:**
CLAIMANT'S NAME (if different from the employee): **ADDRESS:**	**TELEPHONE NO.:**
EMPLOYEE/CLAIMANT'S ATTORNEY (if any): **FLORIDA BAR NO.:** **ADDRESS:**	**TELEPHONE NO.:**
DATE OF ACCIDENT (disablement date if occupational disease):	**ACCIDENT COUNTY:** **ACCIDENT STATE:**
DETAILED DESCRIPTION OF JOB RESPONSIBILITIES:	**SPECIFIC WORK BEING PERFORMED WHEN INJURY OCCURRED:**
DETAILED DESCRIPTION OF THE ACCIDENT: **PART(S) OF BODY INJURED:**	**IS THIS PETITION FOR MEDICAL BENEFITS ONLY (Y/N):** **AWW 13 WEEKS PRECEDING ACCIDENT:** **CURRENT AWW:** **CURRENTLY WITH SAME EMPLOYER (Y/N):** **CURRENT WORK LEVEL:** **HAS MMI BEEN REACHED (Y/N):** **IF SO, DATE OF MMI:**

1. Jurisdiction: The Judge of Compensation Claims has jurisdiction over the parties and the subject matter of this petition.

2. Managed care grievance procedures, if required, were exhausted under F.S. §440.192(3). The Grievance was dated: _____.

3. Character of disability. The injury/injuries occasioned by the events described above has/have adversely affected the injured employee's capacity to earn in the same or any other employment the wages that the employee was receiving at the time of the injury. Specifically, the injury prevents the injured employee from:

_____
_____
_____
_____.