DEPARTMENT OF FINANCIAL SERVICES
Division of Workers' Compensation - Bureau of Employee Assistance
200 East Gaines Street, Tallahassee, Florida 32399-4225

REQUEST FOR SCREENING

Mail Form to: DIVISION OF WORKERS' COMPENSATION

An application by any party needs completion of information in blocks 1 through 12.

1. Employee Name	2. Social Security Number	3. Date of Accident
4. Address (include apartment number, city, state, & zip code)	5. County	6. Telephone Number ( )

This section to be completed by the injured employee:

I request a Department Screening and whatever services are determined appropriate to return me to suitable gainful employment.

I am applying because _____

I have talked with my employer and:

☐ Employment may be available when I am released to work with permanent restrictions.
☐ Employment within my restrictions has already been offered.
☐ My employer has told me no work is available in my same job or a modified or different job.

Employee's Signature	Date

7. Employer/Company Name	8. Employer/Company Address (include city, state & zip code)
9. Telephone Number ( )	
10. Carrier or SC/TPA Name	11. Carrier or SC/TPA Address (include city, state & zip code)
12. Telephone Number ( )	

I believe that the above-referenced employee is entitled to a Department screening for reemployment services.

Employer or Carrier Signature/ Title	Date
☐ Check here if employer referral.	☐ Check here if carrier referral.