

**FLORIDA DEPARTMENT OF FINANCE SERVICES
DIVISION OF WORKERS' COMPENSATION
OFFICE OF SPECIAL DISABILITY TRUST FUND
200 East Gaines Street
Tallahassee, Florida 32399-4223
PREFERRED WORKER REIMBURSEMENT REQUEST**

SDTF RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE NAME	SDTF CLAIM NUMBER	DATE OF ACCIDENT
EMPLOYER NAME	EMPLOYER/FEIN NUMBER	DATE OF HIRE
HOURLY RATE OF PAY	CLASS CODE	SIC CODE

THE FOLLOWING MUST BE ATTACHED:

- 1) UCT-6 (OR OTHER ACCEPTABLE DOCUMENTATION OF PAYROLL AND JOB CLASSIFICATION FILED WITH THE DIVISION OF UNEMPLOYMENT COMPENSATION FOR ALL QUARTERS FOR WHICH REIMBURSEMENT IS REQUESTED).
- 2) COPY OF THE PREMIUM CALCULATION SHEET.
- 3) COPY OF THE PREMIUM AUDIT.

PERIOD FOR WHICH REIMBURSEMENT IS REQUESTED FROM: TO:	TOTAL AMOUNT REIMBURSEMENT REQUESTED
TOTAL REIMBURSED PRIOR TO THIS REQUEST	
NAME AND ADDRESS OF PAYEE:	COMMENTS:
PAYEE'S FEDERAL TAX I.D. NUMBER:	
MAIL CHECK TO:	

I HEREBY CERTIFY THAT ALL SUMS LISTED ON THIS FORM HAVE BEEN PAID.

PREPARER'S SIGNATURE:	SIGNED BY:	EMPLOYER NAME, ADDRESS & TELEPHONE
PREPARER'S TYPED NAME:	TITLE:	
PREPARER'S TELEPHONE NUMBER:	DATE:	

NOTE: This report **MUST BE SIGNED** by the employer or his duly authorized agent or carrier. **SUPPORTING RECORDS** are subject to audit by the Division of Workers' Compensation. The signed original and one copy **MUST BE FILED WITH THE FUND** by the employer requesting reimbursement.

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 IS GUILTY OF A FELONY OF THE THIRD DEGREE.