

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 1-850-922-8953

Received by Claims- Handling Entity	Sent to Division Date	Division Received Date

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION (Fill in Shaded Areas)

Name (First, Middle, Last):		Social Security Number: - -	Date of Accident (Month-Day-Year): / /	Time of Accident: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Home Address: Street/Apt #: City: State: Zip:		Employee's Description of Accident (Include Cause of Injury):		
Telephone (Area Code & Number):				
Occupation:				
Date of Birth: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Injury/Illness that Occurred:		Part of Body Affected:

EMPLOYER INFORMATION (Fill in Shaded Areas)

Company: Lake County Board of County Commissioners D.B.A.: Human Resources Department Street: 315 West Main Street, PO Box 7800 City: Tavares State: Florida Zip: 32778-7800		Federal ID Number (FEIN) : 596000695	Date First Reported (Month-Day-Year): / /
Telephone Number: Area Code & Number 1-352-343-9596		Nature of Business: Governmental	Policy/Member Number:
Employer's Location Address (if different) Street: City: State: Zip: Location # (if applicable) :		Date Employed: / /	Paid for Date of Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No
Place of Accident (Street, City, State, Zip) Street: City: State: Zip: County of Accident:		Last Date Employee Worked: / / Returned to Work: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, give date: / /	Will you continue to pay wages instead of Worker's Comp?: <input type="checkbox"/> Yes <input type="checkbox"/> No Last day wages will be paid instead of Worker's Comp.: / /
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 Florida Statute 817.234, Section 440.105 (7), F.S.		Date of Death (If applicable): / /	Rate of Pay: \$ Per <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Day <input type="checkbox"/> Month
Employee Name / Date		Agree with description of accident?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of hours per day: Number of hours per week: Number of days per week:
Supervisor Name / Date		Name, Address and Telephone of Physician or Hospital Physician: Address: Telephone: Hospital: Authorized by Employer: <input type="checkbox"/> Yes <input type="checkbox"/> No	

CLAIMS-HANDLING ENTITY INFORMATION

<input type="checkbox"/> 1. (a) Denied Case - DWC-12, Notice of Denial Attached <input type="checkbox"/> 1. (b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached <input type="checkbox"/> 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 _____ <input type="checkbox"/> T.T. <input type="checkbox"/> T.T. - 80% <input type="checkbox"/> T.P. <input type="checkbox"/> I.B. <input type="checkbox"/> P.T. <input type="checkbox"/> DEATH <input type="checkbox"/> SETTLEMENT ONLY Penalty Amount Paid in 1st Payment \$ _____ Interest Amount Paid in 1st Payment \$ _____		<input type="checkbox"/> 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: ____ / ____ / ____	
Remarks:	Insurer Code #: 9808	Employee's Class Code:	Employer's NAICS Code: 921190
Service CO/TPA Code #: 6060	Claims-Handling Entity File #:		Insurer Name Claims-Handling Entity Name, Address, & Telephone: Ascension Benefits & Insurance Solutions 700 Central Parkway Stuart, FL 34994 Tele: 1-800-431-2221 Fax: 1-772-220-1637

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. 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.

The employee should use the authorized Healthcare Provider below for non-emergency medical treatment.

Centra Care

Mount Dora Location

19015 U.S. Highway 441

Mount Dora, FL 32757

Main: (352) 383-6479, Fax: (352) 735-0517

Mon - Fri – 8:00 AM to 08:00 PM

Sat – Sun – 8:00 AM to 05:00 PM

Clermont Location

15701 State Road 50, Suite 101

Clermont, FL 34711

Main: (352) 394-7757, Fax: (407) 200-2584

Mon – Fri – 8:00 AM to 08:00 PM

Sat - Sun – 8:00 AM to 05:00 PM