

**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)
HOME ADDRESS Street/apt. #: _____ City: _____ State: _____ Zip: _____		EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)	
TELEPHONE Area Code Number		INJURY/ILLNESS THAT OCCURRED	
OCCUPATION		PART OF BODY AFFECTED	
DATE OF BIRTH	SEX		
____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F		

COMPANY NAME <u>Palm Beach County School Board</u>		FEDERAL I.D. NUMBER (FEIN) <u>59-6000783</u>	DATE FIRST REPORTED (Month/Day/Year)
D.B.A. _____		NATURE OF BUSINESS <u>School District</u>	POLICY/MEMBER NUMBER <u>N/A</u>
Street: <u>3370 Forest Hill Blvd. - Suite A-103</u>			
City: <u>West Palm Beach</u> State: <u>FL</u> Zip: <u>33406</u>		DATE EMPLOYED ____/____/____	PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO
TELEPHONE Area Code Number		EMPLOYER'S LOCATION ADDRESS (if different) Street: _____ City: _____ State: _____ Zip: _____	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES
		LOCATION # (if applicable) <u>9007</u>	LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS COMP ____/____/____
PLACE OF ACCIDENT (Street, City, State, Zip) Street: _____ City: _____ State: _____ Zip: _____		DATE OF DEATH (if applicable) ____/____/____	RATE OF PAY \$ _____ PER <input type="checkbox"/> HR <input type="checkbox"/> WK <input type="checkbox"/> DAY <input type="checkbox"/> MO
COUNTY OF ACCIDENT _____		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 _____
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 440.150(7) F.S. I have reviewed, understand and acknowledge the above statement.			NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL
EMPLOYEE SIGNATURE (if available to sign) _____		DATE _____	AUTHORIZED BY EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER SIGNATURE _____		DATE _____	

**CLAIMS-HANDLING ENTITY INFORMATION**

1(a) Denied Case - DWC-12, Notice of Denial Attached       2. Medical Only became Lost Time Case (Complete all required information in #3)

1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached      Employee's 8<sup>TH</sup> Day of Disability \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Entity's Knowledge of 8<sup>TH</sup> Day of Disability \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

3. Lost Time Case - 1st day of disability \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date First Payment Mailed \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Full Salary in lieu of comp?  YES      Full Salary End Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
AWW \_\_\_\_\_      Comp Rate - \_\_\_\_\_

T.T.     T.T. 80%,     T.P.     I.B.     P.T.     DEATH     SETTLEMENT ONLY

Penalty Amount Paid in 1<sup>st</sup> Payment \$ \_\_\_\_\_      Interest Amount Paid in 1<sup>st</sup> Payment \$ \_\_\_\_\_

REMARKS:		INSURER NAME <b>PALM BEACH COUNTY SCHOOL BOARD</b>	
		CLAIMS-HANDLING ENTITY NAME ADDRESS & TELEPHONE <b>F. A. RICHARD &amp; ASSOCIATES (FARA)</b> 1801 Clint Moore Road, Suite 106 Boca Raton, FL 33487	
INSURER CODE # <u>9379</u>	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE <u>9199 SC</u>	FAX (561) 988-2035 or 988-0360 (FAX Within 24 Hrs.) Phone 1-800-482-3272 After 5PM 1-800-666-3439
SERVICE CO/TPA CODE # <u>6138</u>	CLAIMS-HANDLING ENTITY FILE #		

## 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.