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

INJURY/ILLNESS THAT OCCURRED | PART OF BODY AFFECTED

DATE OF BIRTH ____/____/____
SEX ☐ M ☐ F

EMPLOYER INFORMATION

COMPANY NAME: ____
D. B. A.: ____
Street: ____
City: ____ State: ____ Zip: ____

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

TELEPHONE Area Code Number

DATE EMPLOYED ____/____/____

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)
Street: ____
City: ____ State: ____ Zip: ____
LOCATION # (If applicable) ____

LAST DATE EMPLOYEE WORKED ____/____/____

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

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

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

PLACE OF ACCIDENT (Street, City, State, Zip)
Street: ____
City: ____ State: ____ Zip: ____
COUNTY OF ACCIDENT ____

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

RATE OF PAY
$ ____ PER ☐ HR ☐ WK ☐ DAY ☐ MO

AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ 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 440.105(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 NAME

INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE #	CLAIMS-HANDLING ENTITY FILE #

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE
Johns Eastern Company, Inc.
Post Office Box 110279
Lakewood Ranch Fl 34211-0004

Form DFS-F2-DWC-1 (03/2009) Rule 69L-3.025, F.A.C.

Revised 8/1/13

JOHNS EASTERN COMPANY, INC. Third Party Administrators
MEDICAL MANAGEMENT DEPARTMENT P.O. Box 3318 • Sarasota, FL 34230
TELEPHONE (941) 907-3100 • TOLL FREE: 1-800-749-3044 • TOLL FREE FAX: 1-888-405-3100

FRANKLIN COUNTY SCHOOL BOARD
PANHANDLE AREA EDUCATIONAL CONSORTIUM (PAEC)
REFERRAL FOR MEDICAL SERVICES FORM

This is a temporary workers compensation program I.D. Form.
This form is not a guarantee of eligibility for workers compensation benefits.

SECTION I - To be completed by EMPLOYER

EMPLOYER NAME: ______________________________

EMPLOYEE NAME: ______________________________

DATE OF INJURY ______________ PLACE OF INJURY: ______________________

STATE BODY PART INJURED: ______________________ ISSUED BY: ______________________

IMPORTANT INFORMATION FOR HOSPITALS AND PHYSICIANS

Johns Eastern Company's Medical Management Department has been engaged by PAEC to administer their Medical Management Arrangement under Florida Statute 440.

You are presently treating the above employee for an injury alleged to have occurred during his/her employment with the aforementioned employer. We call to your attention that "light duty" will be available in conjunction with ON-THE-JOB injuries.

YOU MUST CALL Johns Eastern Company at (800) 749-3044 prior to any treatment/admission other than an emergency situation. In an emergency, you must call within 24-hours of treatment.

SEND BILLS TO:

JOHNS EASTERN COMPANY
P.O. BOX 3318
SARASOTA, FL 34230

SECTION II - To be completed by HEALTH CARE PROVIDER ✗

NAME OF INJURED EMPLOYEE: ______________________________

DATE OF TREATMENT: ______________ DATE OF APPOINTMENT FOR FURTHER TREATMENT: ______________

DIAGNOSIS: ______________________________

REMARKS BY M.D.: ______________________________

MAY RETURN TO WORK DATE: ______________ REGULAR ______________ RESTRICTIONS ______________

RESTRICTIONS: ______________________________

NAME OF TREATING PHYSICIAN: ______________________________
(Please Print Full Name)

SIGNATURE OF TREATING PHYSICIAN: ______________________________

PLEASE COPY TO:

1. Johns Eastern Co., Inc. *2. Employer Copy* *3. Medical Provider Copy* *4. PAEC*

Revised 8/1/13