<u>Employer Instructions for Completing the LES Form DWC-1</u>

(First Report of Injury or Illness)

The **LES Form DWC-1**, or ***First Report of Injury or Illness***, is the form used to report workers' compensation accidents or work-related illnesses to your insurance carrier or designated claims office. Delays and errors may increase costs related to processing the claim. Your prompt involvement from the beginning is very important. Regular contact with the injured employee shows your concern with his/her health and that you value his/her return to work. Your commitment can assist in achieving the intent of the workers' compensation system of returning the injured employee to work, at a reasonable cost to you.

Your insurance carrier may allow different methods for reporting the accident information to them; either by sending the LES Form DWC-1 itself, or by submitting the information electronically. If sending the form to your insurance carrier, be sure that you use the current revised LES Form DWC-1 (revised 11/'94). To avoid a fine of up to $500 for late reporting, the top two sections ("Employee" and "Employer" sections) of this form must be completed in full and reported to your insurance carrier within ***7 days from your knowledge of the injury or disease, unless it is a first aid case.*** A first aid case is a work injury or illness which is treated at the workplace, does not require medical treatment for which charges are incurred, and does not cause the employee to miss work for more than one shift. If you are in doubt whether the workplace injury is a first aid case, still file the LES Form DWC-1 with your insurance carrier. A copy of the LES Form DWC-1 goes to the employee, two copies go to your insurance carrier (Division and Carrier copies) and you keep one copy for your files, which should be kept for not less than 2 years, 6 months.

Do <u>not</u> send a copy of the LES Form DWC-1 to the Division. Your insurance carrier will complete its portion of the LES Form DWC-1 and send it to the Division.

<u>Remember:</u> An employer must report all death cases to the Division of Safety by telephone (850) 488-3044, telegram (address: 2002 Old St. Augustine Road, Building E, Tallahassee, Florida 32301), or fax to (850) 922-4538 within 24 hours of knowledge of an employee's death due to a workplace accident or illness.

When completing the LES Form DWC-1:

- Please be sure all parts of the "Employee" and "Employer" sections are complete and legible.

- The LES Form DWC-1 must include the Employee's Name, Social Security Number, or Passport Number, complete date and time of accident.

- Your Insurance Carrier/Third Party Administrator (TPA) will supply you with copies of the LES Form DWC-1. The forms will include your insurance carrier's name, address and phone number pre-printed or pre-stamped. If the name, address and phone number are not pre-printed on the LES Form DWC-1, please contact your Insurance Carrier.

- If the employee is not available to sign, do not delay filing this report, just indicate that the employee is "not available to sign" and hand deliver or mail the employee his/her copy.

- The following information should be supplied when completing the ***Employer Information*** section (please type or print):

    - Your company's full name (no abbreviations) and its complete address and zip code, phone number (including area code). Also provide the name your company is "doing business as," if different from the parent company name.

    - You will need to provide the "**Employer's Location**" if the location of your business is different from the address given above.

    - "**Place of Accident**" is the exact location where the accident occurred. If it is the same as the company name and address, you may enter "same as above."

    - "**County of Accident**" is the name of the county where the accident occurred.

    - "**Federal I.D. Number (FEIN)**" is the employer's identification number assigned by the U.S. Government for tax and unemployment compensation purposes. If a federal employer identification has not been assigned, enter the business owner's social security number that is used for tax reporting purposes.

- “**Nature of Business**” - state the primary nature of your business.

- “**Date Employed**” is the first day the injured employee worked for you.

- “**Last Day Employee Worked**” is the last day that the injured employee reported to work and received wages.

- “**Returned To Work**” - check “yes” or “no” and, if “yes,” give the date on which the employee returned to work.

- “**Date of Death**” is the date the employee died (if applicable).

- “**Agree With Description of Accident?**” - check “yes” if you agree with the employee’s account of how the accident occurred. Check “no” if you disagree with the employee’s account or that an accident happened and explain why you disagree on an attached sheet of paper.

- “**Date First Reported**” is the exact date (month/day/year) when you or any of your supervisors had knowledge that an accident occurred or the exact date that an employee first informed you an accident occurred.

- “**Policy/Member Number**” is the complete policy number for your workers’ compensation insurance policy.

- “**Paid For Date of Injury**” - was the injured employee paid for the date of the injury? Check “yes” or “no”.

- “**Will You Continue To Pay Wages Instead of Workers’ Comp?**” - check “yes” if you will pay the employee while out of work due to the injury.

- “**Last Day Wages will be paid instead of Workers’ Comp**” - enter the last day for which the employee will be paid wages (if known at the time of filing).

- “**Rate of Pay**” is the employee’s exact rate of pay in dollars and cents. Check “HR” if the amount provided is by the hour. Check “WK” if the amount provided is paid by the week. Check “DAY” if the amount provided is by the day. Check “MO” if the amount provided is paid by the month. Enter the number of hours worked per day, the number of hours worked per week and the number of days worked per week.

- “**Name, Address and Telephone Of Physician Or Hospital**” - provide the name, complete mailing address (with zip code) and telephone number (including area code) for the hospital or physician that treated the injured employee. Also check the appropriate box provided, if the physician/medical provider was/was not authorized by you.

Wage Statement:

Within fourteen (14) days after you have knowledge of a lost time case, you must report wage information to your insurance carrier on **LES Form DWC-1A**, **Wage Statement** (be sure that you have the 11/’96 revised version). A ***lost time case*** is a work injury or illness which has caused the employee to be out of work for more than seven days or for which indemnity benefits have been paid.
You must also provide a copy of the completed LES Form DWC-1A and any corrected form, to the employee or his/her estate if deceased. A copy of this form is attached, including instructions for completing this form located on the reverse side.

If you feel that you still need additional assistance in completing the
First Report of Injury /Illness, please call the **Division of Workers’ Compensation, Bureau of Research and Education,**
Customer Education and Information Services Section at **(850) 921-6966**.

This publication is being offered as an informational tool only, with the understanding that this is not official language of the Florida Statutes. In no event, will the State of Florida, Department of Labor and Employment Security, Division of Workers’ Compensation be liable for any direct, indirect or consequential damages resulting from the use of this printed material.

“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 a felony of the third degree.”