



RISK MANAGEMENT DIVISION

115 S. Andrews Avenue, Room 210 • Fort Lauderdale, Florida 33301-1869 • 954-357-7200 • FAX 954-357-6545
Workers' Compensation: FAX 954-357-7176 - Liability: FAX 954-357-7187

MEMORANDUM

NOTICE OF COLLECTING SOCIAL SECURITY NUMBER FOR GOVERNMENT PURPOSE

The Florida Public Records Law (specifically, section 119.07(5)2.a., Florida Statutes (2007), provides that Broward County must give you a written statement describing the law under which the County is collecting your Social Security Number or the County finds that it is imperative to collect your Social Security Number.

Broward County, Division of Risk Management, must collect your Social Security Number pursuant to the following federal or state law/laws: Florida State Statute Chapter 440 Workers' Compensation.

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

EMPLOYER INFORMATION

COMPANY NAME: _____ D. B. A.: _____ Street: _____ City: _____ State: _____ Zip: _____	FEDERAL I.D. NUMBER (FEIN)	DATE FIRST REPORTED (Month/Day/Year)
TELEPHONE Area Code Number	NATURE OF BUSINESS	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 WORKERS' COMP? <input type="checkbox"/> YES LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP ____/____/____
	DATE OF DEATH (If applicable) ____/____/____ AGREE WITH DESCRIPTION OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	RATE OF PAY <input type="checkbox"/> HR <input type="checkbox"/> WK \$ _____ PER <input type="checkbox"/> DAY <input type="checkbox"/> MO 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.		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 which became Lost Time Case (Complete all required information in #3)

1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached 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 Broward County Board of County Commissioners Risk Management Division CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE 115 S. Andrews Ave., Suite 210, Ft. Lauderdale, FL 33301 (954) 357-7200
INSURER CODE # 9145	EMPLOYEE'S CLASS CODE	
SERVICE CO/TPA CODE #	EMPLOYER'S NAICS CODE 921120	
CLAIMS-HANDLING ENTITY FILE #		