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: Volusia County Schools

D. B. A.: _____

Street: 200 North Clara Ave

City: Deland State: FL Zip: 32721

TELEPHONE Area Code Number
386-734-7190

FEDERAL I.D. NUMBER (FEIN)
59-6000884

NATURE OF BUSINESS
Education

DATE FIRST REPORTED (Month/Day/Year)

POLICY/MEMBER NUMBER
Self-Insured

DATE EMPLOYED _____ / _____ / _____

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)

Street: _____

City: _____ State: FL Zip: _____

LOCATION # (If applicable) Ctr #: _____

LAST DATE EMPLOYEE WORKED _____ / _____ / _____

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

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

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

PLACE OF ACCIDENT (Street, City, State, Zip)

Street: _____

City: _____ State: FL Zip: _____

COUNTY OF ACCIDENT Volusia

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

AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO

RATE OF PAY ☐ HR ☐ WK
$ _____ PER ☐ DAY ☐ 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.

_____ 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 CODE # | EMPLOYEE'S CLASS CODE | EMPLOYER'S NAICS CODE

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

INSURER NAME
United Self Insured Services

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

P.O. Box 616648
Orlando, FL 32861-6648
(407) 352-0374 (800) 444-9098
Fax (407) 352-5788

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.

VOLUSIA COUNTY SCHOOLS

COMPREHENSIVE ACCIDENT REPORT

DATE OF REPORT	SCHOOL/FACILITY		
NAME OF INJURED			
HOME ADDRESS (street, city)			
HOME PHONE	GRADE OR OCCUPATION	SEX	AGE
DATE OF ACCIDENT		TIME OF ACCIDENT	

INJURED PARTY (Check One)
Student ____
Employee ____
Parent ____
Vendor ____
Visitor ____
Other ____

PART OF BODY INJURED
☐ Abdomen ☐ Arm ☐ Back ☐ Chest ☐ Eye ☐ Finger ☐ Foot ☐ Head ☐ Leg ☐ Hand ☐ Other _____

NATURE OF INJURY
☐ Amputation ☐ Bite ☐ Bruise ☐ Burn ☐ Concussion ☐ Cut ☐ Dislocation ☐ Fracture ☐ Puncture
☐ Scald ☐ Scratches ☐ Sprain ☐ Other _____

TREATMENT STATUS

☐ Clinic	☐ Sent to Doctor	☐ Sent to Hospital
___ Treated and returned to class	___ With parent	___ With parent
___ Notified parents	___ Other	___ Ambulance or EVAC
___ Other individual notified		___ Other
___ Sent home		

LOCATION OF ACCIDENT (be specific i.e. bldg., rm., play ground) _____

COMPLETE DESCRIPTION OF ACCIDENT

SUPERVISING INDIVIDUAL (at time of accident) _____

WITNESS (name)	Grade or occupation	Phone number
WITNESS (name)	Grade or occupation	Phone number

SIGNATURE OF INJURED (adult only) _____

PREPARED BY (if other than injured individual) _____

ADDITIONAL INFORMATION OR COMMENTS _____

PRINCIPAL/FACILITY MANAGER (signature) _____

This form must be completed in its entirety within 24 hours and forwarded immediately to the Safety Services Department
Send COMPLETED ORIGINAL (white copy) to Safety Services ***Retain CANARY COPY for your files***

Distributed by Safety Services
Revised 4/6/04
2004-282-VCS

Volusia County Schools

Workers' Compensation – Employee Acknowledgement

In order to provide quality medical care in the event of a work-related injury or illness, the Volusia County School District has instituted a Medical Management Program for Workers' Compensation with AmeriSys, which includes the Coventry Network of medical providers. Claims will be administered by United Self Insured Services (USIS). Any treatment received apart from the provider(s) authorized by USIS is the responsibility of the employee.

I understand it is my responsibility to:

- **Immediately report any work-related injury or illness to my immediate supervisor and benefit contact person at work site**
- **Complete a *Comprehensive Accident Report***
- **Review and sign the *First Report of Injury or Illness* prepared by the designated benefit contact and the *Employee Acknowledgement* Form**
- **Review the *Employee Facts* brochure**
- **Understand that only authorized medical care will be provided**
- **Understand that the use of hospital facilities should be for emergency treatment ONLY and requires authorization**
- **Follow the approved primary workers' compensation medical care provider's (i.e. PrimeCare or Centra Care) treatment instructions**
- **Understand that only USIS will authorize and schedule all referrals (ie., orthopedic, physical therapy)**
- **Ensure all medical treatment is handled only through the authorized workers' compensation medical care provider**
- **Direct all questions about the level of care to the third party administrator, United Self Insured Services at 800-444-9098**
- **Obtain prescription through the *My Matrixx* RX authorization plan and understand all prescriptions must be authorized by USIS/AmeriSys**
- **Ensure that all paperwork from the authorized medical facility is returned to supervisor/benefit contact following each visit**
- **10 In Line of Duty Days can be used for workers' compensation medical appointments during working hours for FT/PT employees only. If all In Line of Duty Days have been exhausted, time used for medical appointments during working hours would be taken form employee's time (sick, vacation, etc.)**

Please sign below to indicate that you have read and understand the procedures to follow in the event of an injury or illness and your responsibilities under our managed care arrangement.

Employee's Signature	**Date**
Printed Name	**Department/School Location**

Volusia County Schools

Workers' Compensation - Medical Authorization Treatment Form

PrimeCare Locations:

1890 LPGA Blvd., Suite 130, Daytona Bch. - (386) 274-2212

1327 Saxon Dr, New Smyrna Beach – (386) 767-2402

Prompt Care Location:

1133 Saxon Blvd., Orange City - (386) 878-4137

FL Health Care Location:

2777 Enterprise Rd., Orange City – (386) 774 - 2550

Centra Care Locations:

1014 W Int'l Speedway, Daytona Bch – (386) 872-5044

1245 W. Granada Blvd, Ormond Bch – (386) 317-9055

1208 Dunlawton Ave, Port Orange – (386) 304-7320

2293 S. Woodland Blvd, Deland – (386) 279-7010

1360 Saxon Blvd, Orange City – (386) 917-0074

*All other Centra Care locations are authorized, only Volusia County is listed

Date of Authorization: _____ (Valid for one week from the authorization date)

Name:_____ is authorized to seek medical attention at the designated facility.

Occupation of Injured Employee: _____

_____ _____

Signature of Authorizing Person **Title**

Instructions for Primary Care Physician

Our employee is a valued member of our work team at Volusia County Schools. We have sent this individual to you for immediate, quality care and evaluation of his/her ability to return to work.

Volusia County Schools is willing to temporarily modify the employee's assigned duties to promote and insure his/her safe and effective return to work, if restrictions are recommended.

After you have treated our employee, please complete the DWC-25, specifying any work restrictions. Please fax a copy of all forms to United Self Insured Services (USIS) at 407-352-5788. **Any referrals to a specialty physician must be PRE-AUTHORIZED by USIS, third party administrator for Volusia County Schools.**

- **Please forward all bills to: United Self Insured Services, P.O. Box 616648, Orlando, FL 32861-6648**
- **Please complete the DWC-25 form, per Florida Workers' Comp. Statute.**

Volusia County Schools

Authorized Treatment Facilities

Eastside Locations	Hours
PrimeCare at Twin Lakes 1890 LPGA Blvd., Suite 130 Daytona Beach, FL 32117 Phone: (386) 274-2212 Fax: (386) 274-1508	Monday - Friday, 8 a.m. to 8 p.m. (Please arrive by 7:30 p.m.) Saturday, 8 a.m. to 6 p.m. Sunday & Holidays, 9 a.m. to 6 p.m.
PrimeCare at New Smyrna Beach 1327 Saxon Dr New Smyrna Beach, FL 32169 Phone: (386)-767-2402 Fax: (386)-767-1566	Monday - Friday, 8 a.m. to 8 p.m. (Please arrive by 7:30 p.m.) Saturday, 8 a.m. to 6 p.m. Sunday & Holidays, 9 a.m. to 6 p.m.
Centra Care at Daytona 1014 W Int'l Speedway Blvd Daytona Beach, FL 32114 Phone: (386) 872-5044 Fax: (386) 872-7975	Monday - Friday, 8 a.m. to 8 p.m. (Please arrive by 7:30 p.m.) Saturday & Sunday, 8 a.m. to 5 p.m. (Please arrive by 4:30 p.m.)
Centra Care at Ormond Beach 1245 W. Granada Blvd. Ormond Beach, FL 32174 Phone: (386)-317-9055 Fax: (386)-317-9054	Monday - Friday, 8 a.m. to 8 p.m. (Please arrive by 7:30 p.m.) Saturday & Sunday, 8 a.m. to 5 p.m. (Please arrive by 4:30 p.m.)
Centra Care at Port Orange 1208 Dunlawton Ave Port Orange, FL 32127 Phone: (386)-304-7320 Fax: (386)-304-7374	Monday - Friday, 8 a.m. to 8 p.m. (Please arrive by 7:30 p.m.) Saturday & Sunday, 8 a.m. to 5 p.m. (Please arrive by 4:30 p.m.)
Westside Locations	**Hours**
Centra Care at Deland 2293 S Woodland Blvd DeLand, FL 32720 Phone: (386)-279-7010 Fax: (386)-279-7474	Monday - Friday, 8 a.m. to 8 p.m. (Please arrive by 7:30 p.m.) Saturday & Sunday, 8 a.m. to 5 p.m. (Please arrive by 4:30 p.m.)
Centra Care at Orange City 1360 Saxon Blvd. Orange City, FL 32763 Phone: (386)-917-0074 Fax: (386)-917-0173	Monday - Friday, 8 a.m. to 8 p.m. (Please arrive by 7:30 p.m.) Saturday & Sunday, 8 a.m. to 5 p.m. (Please arrive by 4:30 p.m.)
Florida Health Care 2777 Enterprise Rd Orange City, FL 32763 Phone: 386-774-2550 Fax: (386)-774-5667	Monday – Friday, 7 a.m. to 7 p.m. (Please arrive by 6:30 p.m.) Saturday 8 a.m. to 12 p.m. (Please arrive by 11:30 a.m.)
Prompt Care Urgent Care 1133 Saxon Blvd. Orange City, FL 32763 Phone: 386-878-4137 Fax: 386-878-4293	Monday – Friday, 8 a.m. to 8 p.m. (Please arrive by 7:30 p.m.) Saturday 9 a.m. to 5 p.m. Sunday 9 a.m. to 4 p.m.

*** All Centra Care locations are authorized, only Volusia County locations are listed.

Volusia County Schools

Prescription Authorization

Pharmacy	Location
Walgreens	Any
CVS	Any
Walmart	Any

*** PLEASE PROVIDE THIS FORM TO THE PHARMACY***

Pharmacy Use Only:

BIN # - 003858

PCN # - WC

GROUP # - VS9A

MEMBER ID # – Employee's SSN

If additional authorization is needed please contact USIS 1-800-444-9098 or MyMatrix 877-804-4900.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Autorizaci6n para Obtener Informacl6n Medica

Please sign and return to USIS (Por favor firmar y devolver a USIS)

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") allows disclosures of protected health information in workers' compensation cases, as provided in 45 C.F.R. 164.512(1), which states:
"A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with the laws related to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault."
Florida law establishes workers' compensation coverage in Chapter 440, Florida Statutes.

El acta de portabilidad y responsabilidad de los seguros de salud de 1996 ("HIPAA") permite divulgar informaci6n medica protegida en casos de compensaci6nes de trabajo, provisto en 45. C.F.R. 164.512(1), que dice:
"Una entidad cubierta puede divulgar informaci6n medica protegida autorizada segun lo autorice y en la medida necesaria para cumplir con las leyes relacionadas con la compensaci6n del trabajador u otros programas similares establecidos bajo la ley, que provee beneficios por lesiones o enfermedades relacionadas con el trabajo sin tener culpa." La Ley de Florida establece la compensaci6n para los trabajadores en el capftulo 440 de los estatutos de Florida.

Patient Name (Nombre):
Date of Birth (Fecha de Nacimiento):
Claim Number (Numero de Reclamo):

The undersigned authorizes the release of the medical information specified below to the following entities:
El suscrito autoriza la divulgaci6n de la informaci6n medica especlficada a continuaci6n a las siguientes entidades:

USIS/AmeriSys
PO Box 616648
Orlando, FL 32861-6648

Specific Information to be disclosed:
Any and all medical reports, lab reports, surgical records, medical histories, findings, prognoses, office notes, billing records, and other information or documents relating to any medical treatment, hospitalization, prescription drugs, or other services or supplies, including psychiatric treatment or treatment of alcoholism or drug abuse of the injured employee, by any hospital, medical clinic, surgeon, physician, pharmacist or any other provider of medical services, treatment or supplies. This information will be handled according to HIPAA guidelines expressly for the purpose of administering the workers' compensation claim with date of injury .

Informaci6n especiflcada a ser divulgada:
Todos y cada uno de los informes medicos, informes de laboratorio, registros quirurgicos, historiales medicos, resultados, pron6sticos, notas de la officina, registros de facturaci6n y otra informaci6n o documentos relacionados con cualquier tratamiento medico , hospitalizaci6n, medicamentos recetados u otros servicios o suministros medicos, incluido el tratamiento psiquiatrico o el tratamiento del alcoholismo o el abuso de drogas del empleado lesionado, por cualquier hospital, cl(nica medica, cirujano, medico, farmaceutico o cualquier otro proveedor de servicios medicos, tratamiento o suministros. Esta informaci6n se manejara de acuerdo con las pautas de HIPAA expresamente con el fin de administrar el reclamo de compensacl6n de1 trabajador con la fecha de la lesi6n .

This **authorization will expire one year from the date it is executed.**
Esta autorizaci6n expirara un ai'lo despues de la fecha de su ejecuci6n.

Injured Employee's Name (Nombre del empleado lesionado):_____

Signature (Firma): _____ Date (Fecha):_____

Consent is necessary by parent, guardian or authorized representative.
Si es necesario el consentimiento del padre, tutor o representante autorizado.

Representative's Name (Nombre del Rep.):_____(Please print/letra de molde)

Signature {Firma):_ Date (Fecha):_____

Fraud Statement Acknowledgement

According to Workers' Compensation statute, effective 10/1/03, if you have a work-related injury you must read and sign this form and return it to us immediately or your benefits may be suspended until your signature is received.

Pursuant to Florida Statute 440.105 (7): "An injured employee or any other party making a claim under this Chapter shall provide his or her personal signature attesting that he or she has reviewed, understands, and acknowledges the following statement:

> 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.

If the injured employee or other party refuses to sign the document attesting that he or she has reviewed, understands, and acknowledges the statement, benefits or payments under this Chapter shall be suspended until such signature is obtained."

Reconocimiento de Declaracion de Fraude

De acuerdo a la Ley de lndemnizacion a los Trabajadores, efectivo el 10/1/03, si usted tiene un accidente de trabajo, usted debera leer, firmar y devolver el documento adjunto immediatamente o sus beneficios seran suspendidos hasta tanto se reciba este documento firmado.

De acuerdo a la Ley de Compensacion de la Florida 440.105 (7): El accidentado u otra persona que haga un reclamo de acuerdo a este capitulo debera proveer sufirma testificando que el o el/a ha revisado, entendido, y reconoce la siguiente dec/araci6n:

> **CUALQUIER PERSONA QUIEN CON CONOCIMIENTO, CON INTENCION DE RACER DANO, DE DEFRAUDAR,0 ENGANAR CUALQUIER PATRONO O EMPLEADO, COMPANIA ASEGURADORA, 0 PROGRAMAS DE AUTOASEGUARADO, SOMETA UN TESTIMONIO DE RECLAMO CON FALSA O INFORMACiON ENGAfolOSA COMETE FRAUDE CONTRA LA COMPAFliA DE SEGUROS , CASTIGADO SEGUN PROVISTO POR EL ESTATUTO 817.234.**

Si el accidentado u otra persona que haga un reclamo, se niega a firmar este documento dando fe de que el o el/a ha revisado, entendido y reconoce la siguiente declaracion, benejicios o pagos elegibles dentro de este capitulo, seran suspendidos hasta tanto la firma sea obtenida.

Signature *(firma)*	Date *(fecha)*
Print Name *(nombre en letra de mo/de)*	Social Security Number *(numero de seguro social)*

PLEASE IMMEDIATELY SIGN AND RETURN TO :
Favor firmar y enviar inmediatamente a vuelta de correo al Especialista de Reclamo:

USIS
CLAIMS DEPT
PO BOX 616648
ORLANDO, FL 32861-6648

What to do in Case of a Work Related Injury?

Reporting an Injury/Illness

It is the responsibility of every employee to report a work-related injury/illness as soon as it happens. The employee must notify his/her supervisor and work-site workers' compensation contact immediately and complete a *Comprehensive Accident Report*. The workers' compensation contact will complete the *First Report of Injury/Illness* Form and will offer medical attention, if needed, with an approved workers' compensation medical management treatment facility. An *Employee Acknowledgement Form* must be reviewed and signed by the employee and a *Medical Authorization for Treatment Form* will be completed by the workers' compensation contact/supervisor if medical care is necessary.

Obtaining Medical Attention

When an employee requires medical treatment for a work related injury/illness, the benefit contact person will complete the *Medical Authorization for Treatment Form* authorizing the employee to be treated and evaluated by our authorized providers for initial medical care. In order for the employee to receive the medical benefits at no cost to them, treatment for the work-related injury/illness (s) must be sought from an authorized facility or provider. The authorized treating physician will evaluate and treat the employee and will give him/her a *Return to Work Status Report* which must be returned to the benefit contact person and supervisor. If follow-up appointments are required, In Line of Duty Days may be used during working hours. If all In Line of Duty Days have been exhausted, time used for medical appointments during working hours would be taken from the employee's time (sick, vacation, etc.).

Referral To Specialist

Services of a specialist require a request from an authorized physician and authorization by the Third Party Administrator, United Self Insured Services (USIS) or the AmeriSys Case Manager.

Prescriptions

Prescription drugs may be obtained at a participating pharmacy at no cost to the employee. All prescriptions must be authorized by USIS/AmeriSys. Volusia County Staff are not authorized to approve prescription release. Contact USIS at 800-444-9098 for instructions as to pharmacy locations for orthopedic devices, such as crutches, splints, boots, etc.

Employee Request for a One Time Change

An injured worker is entitled to a one time change under the medical management agreement and the request must be in writing. Upon receipt, USIS will contact the employee to confirm an understanding of the request and the authorization and transfer of care to another qualified provider will be scheduled.

Maximum Medical Improvement (MMI)

Once you reach a plateau with your care and are at MMI, you are responsible for a $10.00 co-payment for each medical visit after the MMI date, with the exception of emergency care.

Dissatisfaction with Medical Care

If you are dissatisfied with any portion of the treatment or have any problems, please call 1-800-444-9098.

Employee Assistance Office

The Division of Workers' Compensation, Employee Assistance Office (EAO), helps prevent and resolve disputes between injured workers, employers and carriers. If the insurance carrier does not provide benefits to which you believe you are entitled, you may call EAO's toll-free hotline at **1-800-342-1741**. EAO specialists are knowledgeable about the workers' compensation system. They will be able to address your concerns and attempt to prevent or resolve disputes. EAO has offices throughout the state that you can call or visit. You can find EAO statewide locations at http://www.MyFloridaCFO.com/WC/organization/eao_offices.html.

Services provided by EAO include:

- Educating and providing information to you about your claim.
- Assisting you in resolving disagreements regarding your claim, at no cost to you.
- Assisting you with understanding the procedures for filing a Petition for Benefits with a Judge of Compensation Claims.

Information regarding your rights and responsibilities under the Workers' Compensation Law is available in an on-line "Injured Worker Workshop" presentation on the Division's Web site at www.MyFloridaCFO.com/WC/employee/index.html, and answers to frequently asked questions can be accessed at www.MyFloridaCFO.com/WC/faq/faqwrkrs.html.

You may also submit specific questions relating to your claim to us at wceao@MyFloridaCFO.com and receive answers directly by e-mail.

Statute of Limitations

Once you are injured at work or become aware of a workers' compensation injury or illness, you have 30 days in which to report your injury or illness to your employer. Failure to report your injury within 30 days may jeopardize your claim.

Generally, you have two years from the date of your injury or illness to file a claim for workers' compensation benefits. Failure to report your injury or illness within 30 days may be used as a defense against your claim regardless of the two-year statute of limitations for filing a claim. Your eligibility for benefits may also be eliminated one year from the date you last received a wage replacement check or approved medical treatment.

Denial of Benefits

If the insurance carrier does not provide benefits to which you believe you are entitled, or has denied your claim, contact the Employee Assistance Office (EAO). Although the EAO does not provide legal advice, our specialists will answer questions about your rights and responsibilities and may be able to resolve problems you're having with your workers' compensation claim. This help is **free** and available by contacting the EAO at **1-800-342-1741**.

Petition for Benefits

To begin the judicial procedure for obtaining benefits that you believe are due and owing under the law and have not been provided by the employer or insurance carrier, a Petition for Benefits form must be filed with the Office of Judges of Compensation Claims. The form can be accessed at www.jcc.state.fl.us/jcc/forms.asp.

Re-employment Services

If you are unable to perform the duties required for your former job as a result of your work-related injury or illness, you can contact the Department of Education, Division of Vocational Rehabilitation at www.rehabworks.org or call 850-245-3470 for free re-employment services.

Legal Representation

You are not required to have an attorney. If you do hire an attorney to represent you with your workers' compensation claim, the fees and costs may come out of your benefits, unless your employer or workers' compensation carrier is held responsible for paying your attorney fees. Although the Division does not provide legal advice, the Division will answer questions about your rights and responsibilities and may be able to resolve problems you may have with your workers' compensation claim. This help is **free** and available by contacting the Employee Assistance Office at **1-800-342-1741**.

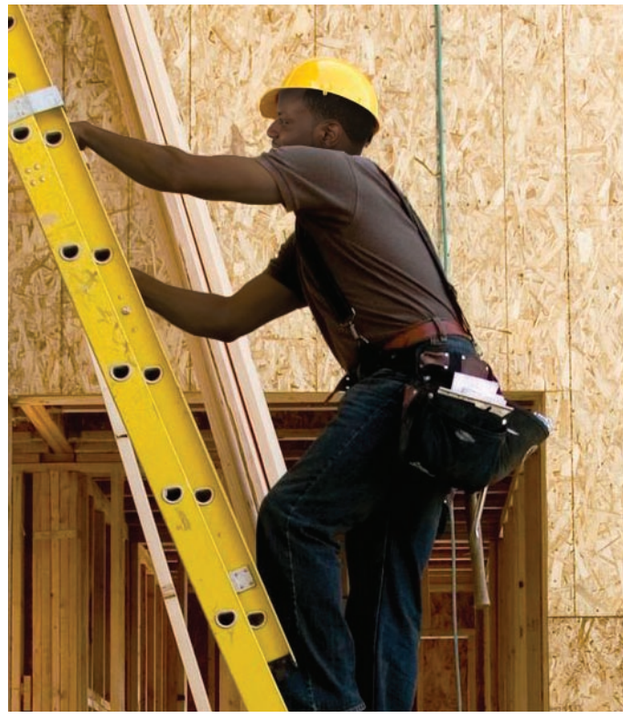
Anti-Fraud Reward Program

Workers' compensation fraud occurs when any person knowingly and with intent to injure, defraud or deceive any employer or employee, insurance carrier or self-insured program files false or misleading information. Workers' compensation fraud is a third-degree felony that can result in fines, civil liability and jail time. Rewards of up to $25,000 may be paid to individuals who provide information that lead to the arrest and conviction of persons committing insurance fraud. To report suspected workers' compensation fraud, call 1-800-378-0445.

Disclaimer:
This publication is being offered as an informational tool only and complies with s. 440.185 (4) F.S., with the understanding that this is not official language of the Florida Statutes. In no event will the Division of Workers' Compensation be liable for direct or consequential damages resulting from the use of this printed material.

69L-3.0035, F.A.C. Injured Worker Informational Brochure
Rule 69L-3.025, F.A.C. Forms
DFS-F2-DWC-60
Revised March 2010

EMPLOYEE FACTS



IMPORTANT

WORKERS' COMPENSATION INFORMATION FOR FLORIDA'S WORKERS

DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

If you are injured as a result of a work-related accident, your employer's workers' compensation coverage may entitle you to medical and partial wage replacement benefits.

Medical Benefits

As soon as your employer's workers' compensation insurance company has knowledge of your work-related injury and has determined that your injury or illness is covered under Florida law, the company will:

- Provide an authorized physician
- Pay for all authorized medically necessary care and treatment related to your injury or illness
- Provide a one-time change of physician within five business days of receipt of your written request

Authorized treatment and care may include:

- Doctor visits
- Hospitalization
- Prostheses
- Physical therapy
- Medical tests
- Prescription drugs
- Travel expenses to and from authorized medical treatment or a pharmacy.

Once you reach maximum medical improvement (MMI), you are required to pay a $10 co-payment per visit for medical treatment. MMI occurs when the physician treating you determines that your injury or illness has healed to the extent that further improvement is not likely.

Wage Replacement Benefits

If you are unable to work or your earnings are lower because of a work-related injury or illness, you may be able to receive some wage replacement benefits. You may be eligible for these benefits if you have been disabled for more than seven calendar days and are not able to perform your normal job duties as advised by your authorized doctor.

If you qualify, wage replacement benefits will begin on the eighth day of partial or total disability. You will not receive wage replacement benefits for the first seven days of disability, unless you are disabled for more than 21 days due to your work-related injury or illness.

In most cases, the wage replacement benefits will equal two-thirds of your pre-injury regular weekly wage, but the benefit will not be higher than Florida's average weekly wage. You can generally expect to receive your first benefit check within 21 days after the carrier becomes aware of your injury or illness and bi-weekly thereafter.

- Temporary Total Benefits: These benefits are provided as a result of an injury or illness that temporarily prevents you from returning to work, and you have not reached MMI.
- Temporary Partial Benefits: These benefits are provided when the doctor releases you to return to work with restrictions and you have not reached MMI and earn less than 80 percent of your pre-injury wage. ***Note: The maximum length of time you can receive temporary total or partial benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.***
- Permanent Impairment Benefits: These benefits are provided when the injury or illness causes any physical, psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a whole.
- Permanent Total Benefits: These benefits are provided when the injury causes you to be permanently and totally disabled according to the conditions stated in the law.
- Death Benefits: Compensation for deaths resulting from workplace accidents include payment of funeral expenses and dependency benefits (subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

The rate, amount and duration of compensation for all wage replacement benefits are detailed in the workers' compensation law. **If you have questions about your benefits, call your claims adjuster or the Employee Assistance Office (EAO) at 1-800-342-1741.**

Injured Worker Responsibilities

Communicate with the Employer:

- Contact your employer immediately to notify them of your on-the-job injury or illness.
- Provide your employer a copy of the Medical Treatment/Status Reporting form (DWC25) after each medical appointment.
- Return to work when you are released by your physician and when your employer offers a position within your physical limitations to avoid suspension of your lost wage benefits.

Communicate with the Carrier:

- Review the First Report of Injury or Illness (DWC1) form upon receipt and verify the accuracy of your address, phone number, social security number and the description of the accident. If there is information you do not agree with, or if information has been omitted, immediately notify your adjuster in writing.
- Review, sign and return the mandatory fraud statement to the insurance carrier. By signing this document, you are confirming your understanding of this important information. Your benefits shall be suspended if you refuse to sign this document.
- Report wages from all sources of employment to the carrier if you had more than one employer in the 13 weeks immediately preceding your date of accident. This will assist the carrier in determining the proper wage replacement amount.
- Keep your adjuster regularly informed on the status of your claim, medical authorization needs and any wages you have earned. (Note: If you are represented by an attorney, the adjuster may not be able to speak with you directly.)
- Notify the carrier of any change of address or telephone number.
- Complete and return forms to the carrier when asked.

Communicate with the Authorized Treating Physician:

- Identify all body parts that are, or potentially may, be injured, and be specific when identifying areas of pain.
- Keep your appointments.
- Clarify your work status during appointments before leaving the physician's office.
- Follow your doctor's treatment plan.
- Ask your physician for the patient copy of the Medical Treatment/Status Reporting form (DWC25).
- Notify your physician of any change of address or telephone number.
- Call the authorized treating physician's office if you need to see the doctor before your next appointment date. The doctor's staff may be able to place your name on a cancellation list and you may be scheduled for an earlier appointment should one become available. If an appointment is not available and you need to see a doctor immediately, please contact your adjuster or the EAO.

Carrier Responsibilities

- Timely provision of medical treatment
- Timely payment of wage replacement benefits
- Timely payment of medical bills
- Timely reporting of your claim information to the Division of Workers' Compensation
- Timely notification of any changes in the status of your claim. This information will be provided to you by mail on either a Notice of Action / Change form (DWC4) or a Notice of Denial form (DWC12).