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: XXX-XX-

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

DATE OF BIRTH ____ / ____ / ____

SEX ☐ M ☐ F

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

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

EMPLOYER'S LOCATION ADDRESS

Street: _____

City: _____ State: FL Zip: _____

LOCATION # (If applicable) Ctr #: _____

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

Street: _____

City: _____ State: FL Zip: _____

COUNTY OF ACCIDENT Volusia

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

NATURE OF BUSINESS
Education

DATE EMPLOYED ____ / ____ / ____

LAST DATE EMPLOYEE WORKED ____ / ____ / ____

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

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

AGREE WITH DESCRIPTION OF ACCIDENT?
☐ YES ☐ NO

DATE FIRST REPORTED (Month/Day/Year)

POLICY/MEMBER NUMBER
Self-Insured

PAID FOR DATE OF INJURY
☐ YES ☐ NO

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

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

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

WORKERS' COMPENSATION – EMPLOYEE ACKNOWLEDGMENT OF DECLINED MEDICAL CARE AND OTHER WORKERS' COMPENSATION BENEFITS

Employee Name	
Date of Incident	
Description of Incident	

I understand that :

- I can change my mind about pursuing a claim under Workers' Compensation for the above-described incident and be provided benefits under Workers' Compensation if I do so before the deadlines prescribed by state law.

- If I change my mind, it is my responsibility to contact the Workers' Compensation Benefits Contact, at my worksite, to complete the rest of the Workers' Compensation Paperwork not previously signed if at any time I believe that an injury occurred within the course and scope of my employment.

- It is only AFTER I follow up with the Workers' Compensation Benefits Contact, that I can seek medical treatment through an authorized Workers' Compensation medical care provider.

- If I choose not to pursue a claim under Workers' Compensation, missed time from work related to the incident will be against my own sick/personal leave if available, or unpaid if not available; and appointments with my personal physician(s) will not be paid for under Workers' Compensation. The use of hospital facilities should be for true medical emergency treatment ONLY and requires advance authorization.

- I understand that Volusia County Schools is relying upon this written indication as to whether the incident is appropriately dealt with through workers' compensation.

- **If at any point, I have questions about my rights or responsibilities, I should contact the Workers' Compensation Analyst, Michelle Gallas at mlgallas@volusia.k12.fl.us or extension 20225.**

If an incident occurs within the course and scope of employment and that incident is the major contributing cause (greater than 50%) of injury or the need for medical care, in many instances, medical evaluation and treatment must be provided through the Workers' Compensation system. Volusia County Schools understands that there can be situations when the employee involved in an incident has knowledge of facts such as pre-existing and/or other medical conditions or circumstances that would make the incident not appropriately dealt with under Workers' Compensation. Volusia County Schools also understands that that employees may wish to keep such information private. Volusia County Schools wishes to both respect employee privacy interests and ensure that any incident that occurs within the course and scope of employment which is or may be the major contributing cause of injury or the need for medical care is handled through Workers' Compensation.

By signing this, I am expressing that I am not seeking medical care or other benefits under Workers' Compensation in connection with the above-described incident. I also agree that I have read and understand the forgoing information regarding my decision to decline Workers' Compensation benefits.

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

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).