MONROE COUNTY BOARD OF COUNTY COMMISSIONERS
EMPLOYEE SERVICES DIVISION, OFFICE OF WORKERS' COMPENSATION
PHONE: (305) 292-4507

1100 SIMONTON STREET, ROOM 2-268
KEY WEST, FLORIDA 33040
FACSIMILE: (305) 295-4301

How to Report a Work Related Injury or Illness

Call 911

In the event of serious injury or work related illness during normal work hours or after normal work hours.

When in doubt call 911 .

- To report non-emergency injuries or illnesses during normal work hours,
- call 305-292-4507.
- To report non-emergency injuries or illnesses *after* normal work hours, call 305-295-4353.
- All injuries or illnesses must be reported as soon as possible but *no later* than 24 hours or fines and penalties may be imposed by the state and or the claim may be denied.

Supervisors must notify the Workers Compensation Office at 305-292-4507 or 305-292-4451 immediately.

1. Complete the First Report of Injury or Illness Form *before* obtaining treatment.(Form DFS-F2-DWC-1).
2. Forms are available on the BOCC web site at: http://www.monroecounty-fl.gov/DocumentCenter/Home/View/1280 or call the WC Office to have them sent to you.
3. Fax the completed forms immediately to Workers' Compensation (WC) Office at (305) 295-4301 before treatment is obtained (unless it is an emergency).
4. Employee must be treated by WC authorized physician. WC cannot authorize any other physician.
5. The treatment authorization must be signed by the WC office BEFORE treatment is rendered.
6. The WC Office will provide the employee with an authorization form for treatment to take to the WC authorized physician.
7. WC has its own Prescription plan. Do not use the regular BOCC prescription card. Show the pharmacy the copy of First Report of Injury or Illness and tell the pharmacy that this is a work related injury or illness. They may ask for : BIN# 005757, Carrier# CTRFL009, Group #, ASCFF.
8. Return the ORIGINAL First Report of Injury or Illness Form completely filled out and signed. It MUST be returned to the WC Office as soon as possible. Courier Stop #1, Gato Building.
9. **ACCIDENT/INCIDENT INVESTIGATION REPORT**: Complete the Accident/Incident Investigation Report as required on all First Report of Injury or Illnesses reported. Be sure that all parties have completed the applicable sections and send the completed form to the WC office. All Reports are reviewed by the Monroe County Safety Officer and discussed at the Safety Accident Review Board Meetings.
10. **Additional medical services**: The WC Office must authorize additional medical services (labs, xrays, testing, specialist, follow-up) before appointments can be scheduled and or services provided. The WC specialist with coordinate with the employee, their supervisor and the provider. Unauthorized treatment will not meet WC standards nor be reimbursed.
11. **RETURN TO WORK**: The WC Office will inform the supervisor of the employee's work status following the injury and coordinate work restrictions and or light duty if necessary.

Please call the WC Office at 305-292-4507 or 305-292-4451 for further assistance.

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

EMPLOYER/COMPANY

Monroe County Board Of County Commissioners
1100 Simonton Street, Suite 2-268
Key West, FL 33040

FEDERAL I.D. NUMBER (FEIN)
59-6000-749

DATE FIRST REPORTED (Month-Day-Year)

NATURE OF BUSINESS
Municipality

POLICY/MEMBER NUMBER
Self-Insured

TELEPHONE Area Code Number
(305) 292-4448

DATE EMPLOYED

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (if different)

Street:: _____

City: _____ State: ___ Zip: _____

Location # (if applicable):

LAST DAY 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: ___ Zip: _____

County of Accident: _____

DATE OF DEATH (If applicable)

AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO

RATE OF PAY

$ _____ PER ☒ HR ☐ WK ☐ 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 NAME
Monroe County BOCC

INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE
9345		

SERVICE CO/ TPA CODE #	CLAIMS-HANDLING ENTITY FILE #
6060	

CLAIMS-HANDLING ENTITY NAME, ADDRESSS & TELEPHONE
Ascension Benefits & Insurance Solutions of Florida
700 CENTRAL PARKWAY
STUART, FL 34994
TEL: (800) 431-2221
FAX: (772) 220-1637

Monroe County Florida

PLEASE ENSURE THAT ANY HANDWRITING ON THIS FORM IS LEGIBLE

Accident/Incident Investigation Report
Send Immediately to Your Department Head

1. Name		2. Department	
3. Date	/ / Time: AM PM	4. Location	
	mm / dd / yyyy	5. Job Title	

6. Location of Accident

Street Address: | City/Key

7. Activity or task being done at time of accident

8. Witness (include address and Phone)

Name: | Phone:

Street & #: | City:

9. **Describe Accident:**

Was the Injury: | Very Minor | Minor | Moderate | Serious | County Vehicle/Unit ID#

Employee

10. Employee's report on how & why accident occurred:

11. What do you recommend could have been done to prevent this accident from occurring?

Employee Signature: Date:

Supervisor

12. Supervisor report of how & why accident/incident occurred **(include unsafe act, cause & root cause)**

Continue on back ☞

13. What will be done to prevent reoccurrence? (remove, repair, barricade, retrain, etc.)

Supervisor Signature: **Print Name**: Phone: Date

Department Director

14. Department Director Comments & Recommendations:

Dept. Dir. Signature: or: **Sheriff Office** Commander | **Print Name**: Phone: Date:

Division Director

15. Division Director Comments & Recommendations:

Div. Dir. Signature or: **Sheriff Office** Safety Rep. | **Print Name** Phone: Date:

Safety - Risk or Workers Comp

16. Safety, Risk or Workers Comp Administrator Recommendations:

Safety/Risk/Worker Comp Administrator: _____ Date
Signature

Supervisor's Acknowledgement of above recommendations _____ Date _____
Employee's Acknowledgement of above recommendations _____ Date _____

Form with supervisor initials and date must be sent to the Safety Rep & Officer

☐ Copy of completed form to designated Department Safety Representative.
☐ Copy of completed form to Safety Officer

SAF1 4/2011

County of Monroe

The Florida Keys

Employee Services Department
Office of Workers' Compensation
1100 Simonton Street, 2-268
Key West, FL 33040
Telephone: 305-292-4451
Fax: 305-295-4301

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 individual 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.

AUTHORIZATION TO FURNISH MEDICAL/EMPLOYMENT INFORMATION

In order to assist with the handling of my claim with Ascension Benefits Insurance Solutions of Florida, I authorize my employers and all persons with knowledge of my injuries to furnish employment and medical information to Ascension. My understanding of this authorization is as follows:

INFORMATION TO BE RELEASED:

Ascension may request all information related to my claim, including information related to diagnosis, treatment records and bills, medical histories, assessments of my past current and expected physical condition as well as current and historical employment, wage and benefits information. Ascension may either review or photocopy this information.

SOURCES OF INFORMATION:

Ascension may contact the appropriate medical providers, insurance companies, and employers and provide them with a copy of this authorization in order to obtain the necessary information.

USE OF PROVIDED INFORMATION:

Ascension and its representatives (such as lawyers or medical providers retained by Ascension will use this information to verify and evaluate my claim in order to determine and appropriate resolution. Ascension may also release the information to professional organization whose purpose is to detect insurance fraud, and may release it to other insurance companies to whom a claim has or may be submitted.

TIME PERIOD OF THIS AUTHORIZATION:

I understand that this authorization will remain valid until my claim with Ascension is legally concluded. I also understand that I can revoke this authorization at any time by notifying Ascension in writing.

COPIES OF THIS AUTHORIZATION:

I can request a copy of this signed authorization at any time from Ascension.

THIS IS NOT A RELEASE OF MY CLAIM. I UNDERSTAND THAT SIGNING THIS FORM DOES NOT MEAN I HAVE SETTLED MY CLAIM.

Signature _____ Date _____

Print _____