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: _____

D. B. A.: _____

Street: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

DATE EMPLOYED ____/____/____

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)

Street: _____

City: _____ State: _____ Zip: _____

LOCATION # (If applicable) _____

LAST DATE EMPLOYEE WORKED ____/____/____

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

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

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 ☐ 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 NAME
City of Hialeah

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE
Sedgwick
501 Palm Avenue, 3rd Floor
Hialeah, Fl 33010
Tel# 305-883-5910

INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE
9272		

SERVICE CO/TPA CODE #	CLAIMS-HANDLING ENTITY FILE #
6209	

Form DFS-F2-DWC-1 (08/2004)

City of Hialeah

Injured Worker's First Fill Prescription Form

Administered by CorVel (800) 563-8438

Injured Worker's Name: _____

SS#: _____ ***Date of Injury:*** _____

INJURED WORKER INSTRUCTIONS:

On your first Pharmacy visit, **please give this notice to any pharmacy listed on this insert to expedite the processing of your approved Workers' Compensation prescriptions, based on the parameters established by City of Hialeah.** With the CorVel pharmacy program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Form to the pharmacy. You should not incur any costs or co-pays at the pharmacy and you will be allowed up to a **14** day supply of medications.

PHARMACIST INSTRUCTIONS:

Please use the BIN, PCN, and RxGroup number below to process an online/electronic claim to CorVel:

CORVEL CVS CAREMARK

BIN:	**004336**
PCN:	**ADV**
RxGroup:	**RXFFWC464**
Member ID:	**See below to generate ID**

To Generate Member ID: The Injured Worker's 9 digit Social Security Number plus 8 digit Date of Injury will be used as their 17 digit **Member Identification number** when processing their First Fill Prescription: **XXXXXXXXXMMDDYYYY**

Please contact CorVel **Pharmacy Solutions** at (800) 563-8438 for assistance with claims processing

There are over 65,000 Participating Pharmacies in the CorVel Network. Below is a sample listing. Call (800)563-8438 for a complete listing.

CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Dominick's Finer Foods	Ingles Pharmacy	Raley's Drug Center	Von's Pharmacy
Drug Mart	Kroger Pharmacy	Rite Aid Pharmacy	Wal-Mart Pharmacy
Fred's Pharmacy	Longs Drug Store	Safeway Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Marc's Pharmacy	Sav-On Drug Store	Wegman Pharmacy
Giant Food Stores, LLC	Medicine Shoppe	Shoprite Supermarkets	Winn Dixie Pharmacy

CORVEL

Supervisor's Comments

This Accident Was: Unavoidable ( ) Avoidable ( ) As A Result Of: Unsafe Condition ( ) Unsafe Act ( )

Recommendation to Avoid Repetition:

Supervisor Signature

This is to acknowledge that said employee wishes to file a Worker's Compensation Claim, but by my signature, obligates the City to no liability on the claim, and that determination is made by the carrier. I will conduct a thorough investigation of the complaint of injury.

Did employee request Form 70-66? Yes:_____ No:_____

If yes, show the date the form was given to the employee:

Date

Department Head Signature

CITY OF HIALEAH

REQUEST FOR SHORT TERM DISABILITY

_____ _____

DEPARTMENT/DIVISION DATE

I, _____ hereby request Short Term Disability 70-66 from the City for the following on the job injury: (Note: Show date and nature of injury).

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date

_____ Approved/ _____

Department/Division Head Disapproved: Date

_____ Approved/ _____

Risk Manager Disapproved Date

_____ Approved/ _____

Human Resources Director Disapproved Date

****

* *

* From: _____ To: _____ *

* *

* TOTAL HOURS: _____ *

* *

****

Form: 70-66

CITY OF HIALEAH
EMPLOYEE INJURY REPORT
(To be completed by Employee)

Employee's Name (first, middle, last):		
Social Security Number:	Date of Birth:	Sex:
Employee's Home Address:		
Employee's Home Telephone Number:		
Department:		
Supervisor's Name:	Telephone #:	
Occupation:	Employed Since:	
Date of Accident:	Time of Accident:	
Place of Accident (Address):	Employer's Premises: Yes No	
Has this accident happened to you before? Yes No		
Has this accident happened to anyone else in your department? Yes No		
Do you have a second job? Yes No		
If yes, Employer's Name & Telephone #:		
Describe the accident?(State fully what you were doing at the time of the accident. State all factors contributing to the accident.)		
Do you feel this accident was avoidable, and if so, how?		
Describe the part of the body that was injured:		
Witness Name:	Witness Telephone:	
Witness Name:	Witness Telephone:	
Do you wish to see a doctor? Yes:____ No:____ If yes, contact the Risk Management Office at (305-883-8059) for the name of a Doctor. If you have already seen a doctor, please provide name, address and telephone number of doctor		
Name of Doctor:	Telephone Number:	
Address:		
Do you require hospital treatment? Yes:____ No:____ Name of Hospital:		
Are you able to return to work? Yes:____ No:____		

NOTE: Anyone who is injured on the job MUST bring a release from the doctor if he/she required medical treatment. (If you are out more than 24 work hours due to injury, you must bring a statement from the doctor showing you were under his/her care).

Do you wish to be considered for City Short Term Disability? Yes:_____ No:_____

If yes, you must file Form 70-66. **Your Department/Division Head has the form.**

I hereby certify that the above injury happened during working hours while employed by the City of Hialeah, and the report has been made to the best of my knowledge.

Employee Signature

Date Report File

CITY OF HIALEAH

Authorization for Use or Disclosure of Protected Health Information

Release Form

I hereby authorize the use or disclosure of my medical information (also known as protected health information) as described below.

1. I, _____, authorize all persons or entities who provide medical treatment to me to disclose the following medical information in your possession to Sedgwick, its employees, agents, subcontractors and/or authorized representatives of the City of Hialeah.

2. Please provide Sedgwick/City of Hialeah with any and all information in your possession concerning my physical condition, past, present, and future, included but not limited to, healthcare history, diagnosis, condition, treatment or evaluation and other medical information so that they may use it or disclose it to evaluate, administer and resolve my claim related to injuries I received on _____. I understand that the medical information that is disclosed may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Authorization for Use or Disclosure of Protected Health Information

Release Form (Page 2)

3. This authorization shall be in force and effect until my claim related to injuries I received on _____ is resolved, at which time this authorization to use or disclose this protected health information terminates. I understand that I may revoke this authorization by notifying the adjuster from Sedgwick, handling the claim and Robert Lloyd-Still, Acting Risk Manager 501 Palm Ave., 3rd. Floor, Hialeah, Florida 33010, in writing, of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by Sedgwick/City of Hialeah or the Releasing Party in reliance on it before I revoke it.

4. As the person signing this Authorization for Release of Protected Health Information, I understand that I am giving permission to Sedgwick /City of Hialeah to obtain and use protected health information. I understand that information used or disclosed by the recipients may no longer be protected by federal or state law.

5. A copy of this authorization may be accepted with the same authority as the original.

All statements and information given in this Authorization for Use or Disclosure of Protected Health Information are true and accurate to the best of my knowledge and belief.

_____ _____

Name of Applicant (Printed) Name of Applicant (Signature)

_____ _____

Date Social Security Number

City of Hialeah 501 Palm Avenue Hialeah, Florida 33010

Name and address of Employer

CITY OF HIALEAH FIRE DEPARTMENT

WORKMAN'S COMPENSATION MEDICAL AUTHORIZATION

Doctor, Hospital, Clinic Name: _____

Address: _____

Employee
Name:_____Classification:_____Department_____

Nature of
Occurrence:_____

Supervisor Name: Title: Date:

The following to be completed by Physician only.

Description of
injury/illness:_____

_____

_____ TREATED AND MAY RETURN TO FULL WORK STATUS*(For Firefighters see below)

_____ LIMITED WORK (Defined as clerical/administrative functions)

_____ UNABLE TO PERFORM LIMITED WORK

_____ ADMITTED TO HOSPITAL

Additional Comments_____

Physician's Name:_____Title:_____Date:_____

*Full Work Status for Firefighters is defined as: the ability to perform fire fighting functions such as but not limited to: Wearing fire fighting protective ensemble weighing at least 50 lbs., advancing hose lines, increased respiratory workloads, high-temperature environments, climbing stairs with equipment, carrying or dragging victims or heavy equipment.

Forward through the Chain of Command to Fire Administration immediately. This form must be completed every time the employee is seen by a physician.