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: School District of Sumter Co

D. B. A.: _____

Street: 2680 West CR 476

City: Bushnell State: Fl Zip: 33513

TELEPHONE Area Code Number

352-793-2315

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 ____/____/____

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 ☐ 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

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

Johns Eastern Company, Inc
P. O. Box 3318
Sarasota, Fl 34230
941-907-3100 800-749-3044

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

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

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.

JOHNS EASTERN COMPANY, INC. *Claim Adjusters & Third Party Administrators*

SPECIAL ACCOUNT SERVICES P.O. BOX 3318 • SARASOTA, FLORIDA 34230
TEL: (941) 907-3100 • FAX: (941) 527-4040 • TOLL-FREE: 1 (800) 749-3044

Employer: School District of Sumter County
Employee:
D/A:
SSN:
Claim ID:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize ALL PHYSICIANS, medical providers, and insurance companies to release any and all of my medical records to:

Please list names and addresses of all physicians you have treated with in the past 10 years. Include your personal treating physicians.

Complete Name	Complete Address (include zip code, telephone # & area code)

** FRAUD 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.

Employee Signature _____ Date _____

Employee's Name _____ Date of Birth _____

Tmesys First Fill Program

tmesys

INJURED WORKER
PRESCRIPTION CARD

CARRIER	EMPLOYER
Johns Eastern	Sumter County Schools

INJURED WORKER NAME

SOCIAL SECURITY NUMBER | DATE OF INJURY

Notice to Cardholder: This prescription card should be presented to your pharmacy to receive medication for your injury. For information regarding our program or participating pharmacies in your area contact the Tmesys Injured Worker Information Group at 866.599.5426.

Processing Instructions for Pharmacist on back

tmesys

Notice to Pharmacists: Call the Tmesys Pharmacy Help Desk at 800.964.2531 to establish First Fill benefit eligibility and obtain the ID# for online adjudication of approved benefits for the injured worker. Tmesys is the designated workers' compensation PBM for this patient.

Tmesys® Pharmacy Help Desk 800.964.2531

NDC Bin # = 004261; Processing Code = CAL
Envoy Bin # = 002538, Processing Code = *Envoy Acct #*

(Cut along outer dotted line and fold in center)

Your employer and your workers' compensation claims administrator, Johns Eastern, are providing prescription benefits through Tmesys, an online Pharmacy Benefits Manager.

The attached cut-out Tmesys First Fill Prescription card will make the process of obtaining medications for your injury easier and more convenient. Simply present this card to any of our more than 55,000 participating pharmacies nationwide, including Hawaii and Puerto Rico, and your prescription will be filled at no out-of-pocket expense to you. Your use of this card is limited to those prescriptions medically related to an injury that is considered to be covered under the applicable state workers' compensation law.

Should you have any questions regarding our program or for the locations of a participating network pharmacy near you, please contact Tmesys at 866.599.5426.

Sincerely,

Tmesys

HOW TO LOCATE A TMESYS PHARMACY:

1. Call Tmesys at 866.599.5426. A Tmesys representative will be more than happy to assist you with the location of a participating pharmacy in your area.
2. Visit our pharmacy locator on the web at www.tmesys.com. Under the "Quick Link" section to the left of your screen, you'll find the Pharmacy Locator.

tmesys®

Single-Source Solution for Workers' Compensation

P.O. Box 152539
Tampa, FL 33684-5239
Help Desk: 866.599.5426
www.tmesys.com

THE SCHOOL DISTRICT OF SUMTER COUNTY

WORKERS' COMPENSATION MEDICAL AUTHORIZATION FOR TREATMENT

You are authorized to give first aid, medical, or emergency treatment to:

NAME:_____ **SSN:**_____

for a reported work-related injury. If the injury is not the result of employment, this authorization shall apply only as a request for an examination and report.

DATE OF INJURY:_____ **DATE AUTHORIZED:**_____
(Good for 24 Hours ONLY)

PRIMARY TREATMENT SITE

Leesburg

☐ U. S. HealthWorks
Leesburg Medical Center
210 S. Lake Street, Ste. 4
Leesburg, FL 34758
(352)314-9300

SCHOOL/ DEPARTMENT:_____ **AUTHORIZED REPRESENTATIVE:**_____

NOTE: ALL REFERRALS MUST BE APPROVED BY JOHNS EASTERN (1-800-749-3044).
P.O. Box 3318
Sarasota, FL 34230

Original – Employee Yellow – Work Site