**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

**PLEASE PRINT OR TYPE**

<table>
<thead>
<tr>
<th><strong>RECEIVED BY</strong></th>
<th><strong>SENT TO DIVISION DATE</strong></th>
<th><strong>DIVISION RECEIVED DATE</strong></th>
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<tbody>
<tr>
<td><strong>CLAIMS-HANDLING ENTITY</strong></td>
<td></td>
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<tr>
<td><strong>FINGERPRINT INFORMATION</strong></td>
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**EMPLOYEE INFORMATION**

<table>
<thead>
<tr>
<th><strong>NAME</strong></th>
<th><strong>SOCIAL SECURITY NUMBER</strong></th>
<th><strong>DATE OF ACCIDENT</strong></th>
<th><strong>TIME OF ACCIDENT</strong></th>
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<tr>
<th><strong>HOME ADDRESS</strong></th>
<th><strong>EMPLOYEE’S DESCRIPTION OF ACCIDENT (Include Cause of Injury)</strong></th>
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<tr>
<th><strong>OCCUPATION</strong></th>
<th><strong>INJURY/ILLNESS THAT OCCURRED</strong></th>
<th><strong>PART OF BODY AFFECTED</strong></th>
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</thead>
</table>

**EMPLOYER INFORMATION**

<table>
<thead>
<tr>
<th><strong>COMPANY</strong></th>
<th><strong>FEDERAL T.I.D. NUMBER (FEIN)</strong></th>
<th><strong>DATE FIRST REPORTED (Month/Day/Year)</strong></th>
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<thead>
<tr>
<th><strong>DATE AND LOCATION OF ACCIDENT</strong></th>
<th><strong>DATE OF DEATH</strong></th>
<th><strong>RATE OF PAY</strong></th>
<th><strong>PAY FOR DATE OF INJURY</strong></th>
</tr>
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<thead>
<tr>
<th><strong>PLACE OF ACCIDENT (Street, City, Zip)</strong></th>
<th><strong>DATE OF DEATH (If applicable)</strong></th>
<th><strong>WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKER’S COMP?</strong></th>
<th><strong>IF YES, GIVE DATE</strong></th>
</tr>
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<tr>
<th><strong>LOCATION # (If applicable)</strong></th>
<th><strong>DATE EMPLOYED</strong></th>
<th><strong>PAID FOR DATE OF INJURY</strong></th>
</tr>
</thead>
</table>

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<tr>
<th><strong>EMPLOYER’S LOCATION ADDRESS (If different)</strong></th>
<th><strong>LAST DATE EMPLOYER WORKED</strong></th>
<th><strong>LAST DAY WAGES WILL BE PAID INSTEAD OF WORKER’S COMP</strong></th>
</tr>
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<table>
<thead>
<tr>
<th><strong>EMPLOYER</strong></th>
<th><strong>NAME, ADDRESS &amp; TELEPHONE OF PHYSICIAN OR HOSPITAL</strong></th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th><strong>EMPLOYEE SIGNATURE</strong></th>
<th><strong>DATE</strong></th>
<th><strong>AUTHORIZED BY EMPLOYER</strong></th>
</tr>
</thead>
</table>

**CLAIMS-HANDLING ENTITY INFORMATION**

<table>
<thead>
<tr>
<th><strong>CLAIMS-HANDLING ENTITY NAME, ADDRESS &amp; TELEPHONE</strong></th>
<th><strong>INSURER NAME</strong></th>
</tr>
</thead>
</table>

**REMARKS:**

**INSURER NAME**

**INSURER CODE #** | **EMPLOYER’S NAICS CODE** |
|-------------------|--------------------------|

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

Form DFS-F2.DWC-1 (12/2009)
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.
NSU EMPLOYEE STATEMENT REGARDING CAUSE OF ACCIDENT AND REQUEST FOR MEDICAL TREATMENT

Employee Name: ____________________________  SSN: ________________________________

Date of Birth ________________________________  Date of Injury: __________________________

Job Title: ________________________________  Supervisor’s Name __________________________

Employee’s NSU Telephone #: ________________  Supervisor’s Signature: __________________________

Dept. /Center: ________________________________  Supervisor’s telephone #: __________________________

Employee Refused Medical Care at time of Injury  □Yes  □No

List activity prior to accident (work related activity only):

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

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_________________________________________________________________________________________________
WORKERS’ COMPENSATION TREATMENT AUTHORIZATION FORM

This is a Worker’s Compensation Treatment Authorization Form. This Form is not a guarantee of eligibility or compensability for Workers’ Compensation Benefits.

To be completed by employer (please print)

Account Number: F45

Employer Name: Nova Southeastern University

Employer Address: 3301 College Avenue, Ft. Lauderdale, Florida 33314

Employee Name: ________________________________

Social Security Number: ___________________ Date of Injury: _________________

Type of Injury: ____________________

Body Part Injured: ____________________

Supervisor issuing form: Dr. Charmaine Beckford (T) 954-262-5404* 954-262-6860-(F)

Supervisors: Please give this completed form to the injured employee to take with them to the physician.

This form is for one time use, only on this date ________________.

Providers: You must call Cannon Cochran Management Services, Inc. toll free at 1-866-291-0194 prior to any additional treatment/admission or referral, other than an emergency. In an emergency, notification to CCMSI is required within 24 hours.

Send Medical Bills To:

Cannon Cochran Management Services, Inc.
PO Box 948399 | Maitland| FL 32794-8399
1-866-291-0194 | 407-660-5600 | Fax: 217-477-6946 | FICURMA@mail@ccmsi.com
FICURMA
Workers’ Compensation Prescription Information

Employer:
Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

<p>| | |</p>
<table>
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<tr>
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<tbody>
<tr>
<td>Employee Name:</td>
<td></td>
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<tr>
<td>Group#:</td>
<td>P2KA</td>
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<tr>
<td>Member ID (SSN):</td>
<td></td>
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<tr>
<td>Date of Injury:</td>
<td></td>
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<tr>
<td>Processor:</td>
<td>myMatrixx</td>
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<tr>
<td>Bin#:</td>
<td>003858</td>
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</tbody>
</table>

Day supply is limited to 14 days for a new injury.

myMatrixx Help Desk: (877) 804-4900

Employee:
FICURMA has partnered with myMatrixx to make filling workers’ compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist:
Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers’ compensation injury only.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900
AUTHORIZATION FOR MEDICAL RECORDS AND COMMUNICATION RELEASE

Name: __________________________ Date of Birth: ______________ Social Security #: __________________

I hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of my mental or physical health, history, condition or wellbeing, to supply such information to my employer or its insurance carrier, claims administrator or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer or its insurance company, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment, and as to any other issues including diagnosis, prognosis, causal connection of care and treatment to my work injury or duties, and ability to work. I hereby waive my physician-patient privilege. In conjunction with this, I also authorize any treating physician or medical provider to review any additional materials provided to them.

A photocopy of this authorization shall be as valid as the original. This release shall remain valid for the length of my claim.

Note: Workers’ Compensation Requests Are Exempt From HIPAA. Pursuant to 45 CFR, Sect. 164.512(1) a covered entity may without penalty under HIPAA disclose protected health information to the extent necessary to comply with the law relating to workers’ compensation.

________________________________________
NAME-PLEASE PRINT

________________________________________
SIGNATURE

________________________________________
DATE
False and Fraudulent Claim Warning

Please read the following information carefully. This form must be signed and returned within 30 days of the date it was received, stating that you have reviewed, understand and acknowledge the statement of benefits and/or payments shall be suspended until such signature obtained.

Workers’ Compensation fraud includes but is not limited to the following:

• Requesting and/or receiving temporary total, temporary partial, permanent total disability or impairment benefits while working for gain as an employee of a business, independent contractor, yourself or a business and not reporting that income to the insurance company.
• Making a false or written statement and/or submitting false documents to your employer, your physician and/or the insurance company or their representatives for the purpose of filing or supporting a claim for workers’ compensation benefits.
• Misrepresenting facts concerning an industrial accident, injury or illness to your employer, your physician and/or the insurance company or their representatives.
• Failing to report earnings when requested to do so by the insurance company.
• Selling your personal information to third parties for use of misrepresenting facts to any medical provider or insurance company.

Florida
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 Florida Statute 817.234.

I have reviewed, understand and acknowledge the above. This information is true and correct to the best of my knowledge.

Workers Name: ____________________________

Please type or print

Claim #: ____________________________ Employee: ____________________________

Employer: __________________________________________________________

Employees’ Address: ___________________________________________________

Phone: _______________________________________________________________

Workers’ Signature: ____________________________ Date: ____________________________
Workers’ Compensation Witness Report Form (To be completed by witness only)

Name of injured employee: ____________________________________________________________

Name of witness: _________________________________________________________________

Telephone # of Witness: ___________________________________________________________

Location where incident occurred: ___________________________________________________

Date of incident: ____________________   Time of incident: ____________________

1. What were you (the witness) doing at the time of the incident?
   __________________________________________________________

2. How and when did you become aware of the incident?
   __________________________________________________________

3. What did you hear at the time of the incident?
   __________________________________________________________

4. Describe what you saw at the time of the incident:
   __________________________________________________________

5. Who else was present?
   __________________________________________________________

6. Please relate any additional information you have pertaining to the incident:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

Witness’s signature: ______________________________ Date signed: ________________
Please fax or email the completed form to the adjuster for handling. Thank you.

**REQUEST FOR MILEAGE REIMBURSEMENT**

<table>
<thead>
<tr>
<th>NAME:</th>
<th>EMPLOYER: Nova Southeastern University</th>
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<tbody>
<tr>
<td>CLAIM NUMBER:</td>
<td>CLAIMANT ADDRESS:</td>
</tr>
<tr>
<td>WORK ADDRESS:</td>
<td>DATE OF INJURY:</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Date of Visit</th>
<th>Name of Medical Facility (Including Pharmacies) with address</th>
<th>Roundtrip Miles</th>
<th>Residence or Work (Please indicate)</th>
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Total Miles: ___________________________ x 0.444 = $ __________

I hereby certify or affirm that the above mileage was incurred by me as necessary traveling expenses related to those medical facility visits pursuant to my workers' compensation case.

______________________________  ____________________
Signature                               Date