EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY

FLORIDA DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY
Division of Workers' Compensation
1321 Executive Center Drive, East
Tallahassee, Florida 32301
Phone: 1-800-342-1741

ATTENTION:
W.C. Claims Office

EMPLOYER'S FIRM NAME	EMPLOYEE'S NAME (First, Middle, Last)	EMPLOYEE'S SOCIAL SECURITY NO.
EMPLOYER'S MAILING ADDRESS (Include ZIP) c/o Risk Management Division 111 N.W. 1st Street, Suite 2340 Miami, Florida 33128-1987	EMPLOYEE'S PRESENT ADDRESS (Include ZIP)	DATE OF ACCIDENT
TELEPHONE NUMBER (305) 375-4280	TELEPHONE NUMBER	

DAY OF WEEK ACCIDENT OCCURRED _____ HOUR OF DAY _____ A.M. _____ P.M.

DATE EMPLOYEE'S DISABILITY BEGAN _____, 19____.

HAS EMPLOYEE RETURNED TO WORK?_____. IF "YES," ENTER DATE RETURNED_____, 19____.

IS EMPLOYEE EARNING SAME WAGES AS BEFORE INJURY? _____ . IF "NO," PLEASE EXPLAIN _____

_____

IF DISABILITY HAS NOT TERMINATED, STATE PROBABLE DATE OF TERMINATION _____, 19____.

HAS THE EMPLOYEE DIED? _____. IF "YES," ENTER DATE OF DEATH_____, 19____.

EMARKS:

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 IS GUILT OF A FELONY OR THE THIRD DEGREE.

PREPARED BY (Signature)	OFFICIAL POSITION PHONE NUMBER _____	DATE THIS REPORT COMPLETED

160.05-13A 3/92