Avitus Group - Employee Injury Report

Instructions:

- **All injuries must be reported to Avitus Group on the same shift that they happened.** *Questions?* Just call us.
- Please answer all of the questions below as best you can. You will be contacted if more information is needed.
- **Do not delay reporting an injury** if all of the information is not available. Answer as many questions as you can.
- E-Mail to: **Safety@avitusgroup.com** or **Fax this form today to:** (406) 869-7598 ■ Safety & Risk Management

1. Business Name: _____ Location or Store # (if any): _____
2. Street Address: _____
3. City/Town: _____ State: _____ Phone: (_____) _____-_____
4. Employee Name: _____ Job Position/Title: _____
5. Employee's Date of Birth: _____/_____/_____ Is This a Full-Time Employee? ❒ Yes ❒ No
6. Employee's Mailing Address (Address, City, State & Zip): _____
7. Employee's Contact Phone Numbers: (_____) _____-_____ *or* (_____) _____-_____
8. Date Supervisor Was Notified of Injury: _____/_____/_____ How? _____
9. Supervisor's Name: _____ Supervisors Contact Phone: (_____) _____-_____
10. Date and Time of Injury: _____/_____/_____ in County: _____ State: _____
11. Location where the injury happened (shop, job site address, etc.): _____
12. What was the employee doing when injury happened: _____
13. Names(s) of Witnesses: _____
14. Treatment? ❒ None Needed ❒ First Aid ❒ Emergency Dept. ❒ Clinic/Dr. Office ❒ Other _____
15. Was Professional Medical Treatment Required? ❒ Yes – *Continue with this question* ❒ No – Go to #16
    - ■ Name and Location of Medical Provider: _____
    - ■ Phone Number of Medical Provider: (_____) _____-_____
16. Was more than 1 day lost from work? ❒ Yes – *Continue with this question* ❒ No – Go to #17

    If Time Was Lost From Work:
    - ■ First Full Day Off Work: _____/_____/_____ ■ Number of Workdays Lost?_____ Days
    - ■ Date Returned to Work: _____/_____/_____ ■ Number of Days on Restrictions?_____ Days
17. Employee's Usual Work Schedule: _____ Usual Days Off: _____
18. Body Part(s) Injured (right arm, left ankle, back, etc.): _____
19. Describe the Injury (i.e., sprain, strain, fracture, etc.): _____
20. How Did the Injury Happen (cause of injury, use additional pages if needed)?

_____

_____

21. What actions, events or conditions contributed most directly to this Injury (use additional pages if needed)?

_____

22. Corrective Actions Taken (*or will be taken*) on (or by) Date: _____/_____/_____

_____

23. Do you question any aspect of this injury? ❒ No ❒ Yes – If *"Yes"* please explain below – or call us.
24. Are there any other comments *or* information that we should know about (use additional pages if needed)?

_____

_____

25. Name/Title of person completing form: _____ Phone Number: (_____) _____-_____

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

DATE OF BIRTH _____/_____/_____

SEX ☐ M ☐ F

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

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 _____/_____/_____

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

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.