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

Reset Form

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** **TELEPHONE NUMBER (305) 375-4280**	**EMPLOYEE'S PRESENT ADDRESS (Include ZIP)** TELEPHONE NUMBER	**DATE OF ACCIDENT**

DAY OF WEEK ACCIDENT OCCURRED_____**HOURS OF DAY**_____A.M. _____P.M.

DATE EMPLOYEE'S DISABILITY BEGAN_____, **20**_____.

HAS EMPLOYEE RETURNED TO WORK?_____. **IF YES, ENTER DATE RETURNED** _____, **20** _____.

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

_____

IF DISABILITY HAS NOT TERMINATED, STATE PROBABLE DATE OF TERMINATION_____, **20** _____.

HAS THE EMPLOYEE DIED?_____. **IF YES, ENTER DATE OF DEATH** _____, **20**_____.

REMARKS:

ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OF SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

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