

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP) AllStaff Payroll, Inc. 2101 North 9th Ave. Pensacola, FL 32503		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
		JURISDICTION	JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER		
SIC CODE	EMPLOYER FEIN 59-3214402	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION # PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)		POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)	
		TO		
		<input type="checkbox"/> CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE		
CARRIER FEIN	POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN	

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX		MARITAL STATUS	
		<input type="checkbox"/> MALE (M) <input type="checkbox"/> FEMALE (F) <input type="checkbox"/> UNKNOWN (U)		<input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED (U) <input type="checkbox"/> MARRIED (M) <input type="checkbox"/> SEPARATED (S) <input type="checkbox"/> UNKNOWN (K)	
		# OF DEPENDENTS		OCCUPATION/JOB TITLE	
PHONE				EMPLOYMENT STATUS	
				NCCI CLASS CODE	
RATE	PER: <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> OTHER: <input type="checkbox"/>	#DAYS WORKED WEEK	FULL PAY FOR DAY OF INJURY?		YES <input type="checkbox"/> NO <input type="checkbox"/>
				DID SALARY CONTINUE?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	AM <input type="checkbox"/> PM <input type="checkbox"/>	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM <input type="checkbox"/> PM <input type="checkbox"/>	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED		
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE		
COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL							CAUSE OF INJURY CODE
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?				YES <input type="checkbox"/> NO <input type="checkbox"/>	
		WERE THEY USED?				YES <input type="checkbox"/> NO <input type="checkbox"/>	
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL (NAME & ADDRESS)			INITIAL TREATMENT NO MEDICAL TREATMENT (0) <input type="checkbox"/> MINOR: BY EMPLOYER (1) <input type="checkbox"/> MINOR CLINIC/HOSP (2) <input type="checkbox"/> EMERGENCY CARE (3) <input type="checkbox"/> HOSPITALIZED > 24 HRS (4) <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) <input type="checkbox"/>	
WITNESSES (NAME & PHONE #)							
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE			PHONE NUMBER		