FIRST REPORT OF INJURY OR ILLNESS

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 CARRIER	SENT TO DIVISION	DIVISION REC'D DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last): Mathilda F (Faye) Hinson

Social Security Number: 262.45.9887

Date of Accident (Month/Day/Year): 05.11.2010

Time of Accident: 07:55 ☒ AM ☐ PM

HOME ADDRESS
Street/Apt #: 11661 128th Ave
City: Largo State: Florida Zip: 33778

TELEPHONE Area Code: 727 Number: 581.0378

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)
Attempting to fill toilet tissue, inner carriage was stuck, Ms. Hinson tried to remove it and her right forearm was cut by the dispenser edge.

OCCUPATION: Housekeeper

INJURY/ILLNESS THAT OCCURRED: Laceration Right Forearm

PART OF BODY AFFECTED: Right Forearm

DATE OF BIRTH: 11 / 22 / 1958

SEX: ☐ M ☒ F

EMPLOYER INFORMATION

COMPANY NAME: Hospital Housekeeping Systems, Inc
D. B. A.: HHS, INC.
Street: 322 Congress Ave
City: Austin State: Tx Zip: 78701

TELEPHONE Area Code Number: 800.229.2028

FEDERAL I.D. NUMBER (FEIN): 742983259

DATE FIRST REPORTED (Month/Day/Year): 05.11.2010

NATURE OF BUSINESS: Housekeeping

POLICY/MEMBER NUMBER: 65WEPO0038

DATE EMPLOYED: 11 / 11 / 2007

PAID FOR DATE OF INJURY ☒ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)
Street: 201 14th St SW
City: Largo State: Fl Zip: 33770
LOCATION # (If applicable): 281

LAST DATE EMPLOYEE WORKED: 05 / 11 / 2010

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: 201 14th St SW
City: Largo State: Fl Zip: 33770
COUNTY OF ACCIDENT: Pinellas

DATE OF DEATH (If applicable)

AGREE WITH DESCRIPTION OF ACCIDENT? ☒ YES ☐ NO

RATE OF PAY: $ 9.32 PER ☒ HR ☐ WK ☐ DAY ☐ MO

Number of hours per day: 8
Number of hours per week: 40
Number of days per week: 5

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 guilty of a felony of the third degree. I have reviewed, understand and acknowledge the above statement.

EMPLOYEE SIGNATURE (If available to sign) — DATE: 05.11.2010

EMPLOYER SIGNATURE — DATE: 05.11.2010

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL
Largo Medical Center Emergency
201 14th St SW
Largo, Fl 33770 Dr. Leimbacher

AUTHORIZED BY EMPLOYER ☒ YES ☐ NO

CARRIER INFORMATION

☐ 1. Case Denied - DWC-12, Notice of Denial Attached ☐ 2. Medical Only which became Lost Time Case (Complete all info in #3)

☐ 3. Lost Time Case - 1st day of disability _____ / _____ / _____ Salary continued in lieu of comp? ☐ YES Salary End Date _____/ _____ / _____

Date First Payment Mailed _____ / _____ / _____ AWW _____ Comp Rate _____

☐ T.T. ☐ T.T. - 80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ DEATH

REMARKS:

CARRIER NAME, ADDRESS & TELEPHONE

CARRIER CODE #	EMPLOYEE'S RISK CLASS CODE	EMPLOYER'S SIC CODE
SERVICE CO/TPA CODE #	CARRIER FILE #	

Is employer self-insured? ☐ YES ☐ NO

Form DWC-1 (11/94)