**Florida Department of Labor and Employment Security**

**Division of Workers’ Compensation**

**Employee Facts:  Important Workers’ Compensation Information for Florida Workers**

***As required by §440, Florida Statutes***

This letter acknowledges that I have been provided a copy of the “Florida Department of Labor and Employment Security, Employee Facts: Important Workers’ Compensation Information for Florida Workers” pamphlet.  This pamphlet gives general information about the Florida Workers’ Compensation Program.  Included with this pamphlet is a copy of §440.19 – Time bars to filing petition for benefits, Florida Statutes.  I will familiarize myself with the pamphlet and the statute of limitations period found in §440.19, Florida Statute that was provided to me.  I understand the pamphlet and statute constitute the procedures that must be followed by both Brevard Public Schools and me.

**Florida Department of Labor and Employment Security**

**Division of Workers’ Compensation**

**First Report of Injury or Illness**

This letter acknowledges that I have been provided a copy of the “First Report of Injury or Illness” form or LES form DWC-1.  This shows my description of the accident including the cause.  This form also contains the name of Brevard Public Schools Carrier/Agent: “Sedgwick CMS.”

**Brevard Public Schools**

I have been advised that I am responsible to submit all physician notes returning me to work, limiting my work duties, excusing me from work, or any other type of note affecting my work or volunteer status to my supervisor immediately following the doctor’s appointment.  I acknowledge that if I am unable to provide my doctor’s note to my supervisor on the date of the appointment, I must provide it to my supervisor at the start of my shift the following workday.  In no case shall the form be submitted later than 24 hours of the doctor’s appointment.  Failure to submit a physician note as described above may be grounds for employment discipline up to and including termination.

*Any person who knowingly and with intent to injure, defraud or deceive any employer, employee, insurance company, self-insured program or files a statement of claim containing any false information or misleading information commits a felony of the third degree.  I have reviewed and acknowledge the above statement.*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School/Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Once signed by the injured worker, forward original copy to Office of Employee Benefits and Risk Management**