



# HOWARD LEASING

Professional Employee Services

6302 Manatee Avenue West  
Bradenton, FL 34209  
941-761-7704

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## INJURY REPORTING PROCEDURES

*IF THE INJURY IS AN EMERGENCY, DIAL 911 IMMEDIATELY.*

*After calling 911, please contact Robin Walker at 941-932-5740 as soon as possible. That phone number is available 7 days a week and 24 hours a day.*

**IF THE INJURY IS NOT AN EMERGENCY:**

1. Call Robin Walker immediately upon being notified of any type of injury at 941-761-7704 (during business hours) or 941-932-5740 (during non-business hours and weekends).
2. Fill out the FROI (First Report of Injury Form), the Employee Verification form, the Witness Statement forms and fax them to Howard Leasing at 941-761-7706.
3. A Howard Leasing employee will coordinate which walk-in clinic to send the injured worker to for an evaluation and mandatory drug screen.
4. The 5 Panel Drug Screen is mandatory for all workers' compensation claims. The injured employee must have a drug screen within 24 hours of the injury or the claim can be denied.
5. Please forward all correspondence relating to the injury to: [rwalker@howardleasinginc.com](mailto:rwalker@howardleasinginc.com)

*Please remember, it is imperative that you communicate any injuries to Howard Leasing as soon as you are notified by one of your employees that an injury has occurred. No matter how big or how small, call Howard Leasing immediately. With timely reporting, we will be able to assist your injured employee as efficiently as possible.*

### IMPORTANT NUMBERS:

Robin Walker

941-761-7704 Howard Leasing Office

941-932-5740 Work Comp Cell (24 hours)

941-761-7706 Howard Leasing Fax

- Late reporting of an injury (>24 hours) will result in a \$500 fine from the state.
- Failure to secure a drug screen immediately after the injury may result in a denied claim.
- Please retain any defective equipment or faulty machines for inspection.

**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<br>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<br><input type="checkbox"/> AM <input type="checkbox"/> PM |
| HOME ADDRESS<br>Street/Apt #: _____<br>City: _____ State: _____ Zip: _____ |  | EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury) |                                   |                                                                             |
| TELEPHONE Area Code Number                                                 |  | OCCUPATION                                                   |                                   |                                                                             |
| DATE OF BIRTH                                                              |  | INJURY/ILLNESS THAT OCCURRED                                 |                                   | PART OF BODY AFFECTED                                                       |
| SEX<br><input type="checkbox"/> M <input type="checkbox"/> F               |  |                                                              |                                   |                                                                             |

**EMPLOYER INFORMATION**

|                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                     |                                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| COMPANY NAME: <u>Howard Leasing</u>                                                                                                                                                                                                                                                                                                                                                  | FEDERAL I.D. NUMBER (FEIN)                                                                                          | DATE FIRST REPORTED (Month/Day/Year)                                                                                                            |
| D. B. A.: _____<br>Street: <u>6302 Manatee Ave W</u><br>City: <u>Bradenton</u> State: <u>FL</u> Zip: <u>34209</u>                                                                                                                                                                                                                                                                    | NATURE OF BUSINESS                                                                                                  | POLICY/MEMBER NUMBER<br><u>WCPEO 00004001</u>                                                                                                   |
| TELEPHONE Area Code Number<br><u>941-761-7704</u>                                                                                                                                                                                                                                                                                                                                    | DATE EMPLOYED<br>_____/_____/_____                                                                                  | PAID FOR DATE OF INJURY<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                  |
| EMPLOYER'S LOCATION ADDRESS (If different)<br>Street: _____<br>City: _____ State: _____ Zip: _____<br>LOCATION # (if applicable) _____                                                                                                                                                                                                                                               | LAST DATE EMPLOYEE WORKED<br>_____/_____/_____                                                                      | WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES                                                           |
| PLACE OF ACCIDENT (Street, City, State, Zip)<br>Street: _____<br>City: _____ State: _____ Zip: _____<br>COUNTY OF ACCIDENT _____                                                                                                                                                                                                                                                     | DATE OF DEATH (If applicable)<br>_____/_____/_____                                                                  | RATE OF PAY<br>\$ _____ PER <input type="checkbox"/> HR <input type="checkbox"/> WK<br><input type="checkbox"/> DAY <input type="checkbox"/> NO |
|                                                                                                                                                                                                                                                                                                                                                                                      | RETURNED TO WORK <input type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE DATE<br>_____/_____/_____ | LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP<br>_____/_____/_____                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                      | AGREE WITH DESCRIPTION OF ACCIDENT?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                     | Number of hours per day _____<br>Number of hours per week _____<br>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.<br>I have reviewed, understand and acknowledge the above statement. | EMPLOYEE SIGNATURE (if available to sign) _____<br>EMPLOYER SIGNATURE _____                                         | NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL<br><br>AUTHORIZED BY EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO     |
|                                                                                                                                                                                                                                                                                                                                                                                      | DATE _____<br>DATE _____                                                                                            |                                                                                                                                                 |

**CLAIMS-HANDLING ENTITY INFORMATION**

|                                                                                                                                                                                                                                     |                                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> 1(a) Denied Case - DWC-12, Notice of Denial Attached                                                                                                                                                       | <input type="checkbox"/> 2. Medical Only which became Lost Time Case (Complete all required information in #3) |
| <input type="checkbox"/> 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached                                                                                                                                        | Employee's 8 <sup>TH</sup> Day of Disability _____/_____/_____                                                 |
| <input type="checkbox"/> 3. Lost Time Case - 1st day of disability _____/_____/_____                                                                                                                                                | Entity's Knowledge of 8 <sup>TH</sup> Day of Disability _____/_____/_____                                      |
| Date First Payment Mailed _____/_____/_____                                                                                                                                                                                         | Full Salary in lieu of comp? <input type="checkbox"/> YES Full Salary End Date _____/_____/_____               |
| AWW _____                                                                                                                                                                                                                           | Comp Rate _____                                                                                                |
| <input type="checkbox"/> T.T. <input type="checkbox"/> T.T. - 80% <input type="checkbox"/> T.P. <input type="checkbox"/> I.B. <input type="checkbox"/> P.T. <input type="checkbox"/> DEATH <input type="checkbox"/> SETTLEMENT ONLY |                                                                                                                |
| Penalty Amount Paid in 1 <sup>st</sup> Payment \$ _____ Interest Amount Paid in 1 <sup>st</sup> Payment \$ _____                                                                                                                    |                                                                                                                |

|                         |                               |                       |                                                  |
|-------------------------|-------------------------------|-----------------------|--------------------------------------------------|
| REMARKS:                |                               |                       | INSURER NAME                                     |
|                         |                               |                       | CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE |
| INSURER CODE #          | EMPLOYEE'S CLASS CODE         | EMPLOYER'S NAICS CODE |                                                  |
| SERVICE CODE/TPA CODE # | CLAIMS-HANDLING ENTITY FILE # |                       |                                                  |



*Howard Leasing, Inc.*

6302 Manatee Avenue West Suite K

Bradenton, FL 34209

Phone: (941) 761-7704

Fax: (941) 761-7706

**EMPLOYEE VERIFICATION FORM**  
(TO BE FILLED OUT BY THE INJURED WORKER)

We are attempting to process your worker's compensation claim and need to verify the following information in order for us to determine entitlement to workers compensation benefits.

Please verify that the following information is true and correct:

NAME: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_

In order to receive benefits for my worker's compensation claim, I,

\_\_\_\_\_, attest that the above information is true and correct.

SIGNED NAME: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

DATE: \_\_\_\_\_



Worker's Compensation Questionnaire  
(To be completed by Employee)

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Street Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_ Cell Number: \_\_\_\_\_

This questionnaire is treated as a confidential document and access is limited to a "need to know" basis. Howard Leasing and its affiliates will retain this form on a confidential file and reserve the right to refer to the information in the event of an accident, sickness, injury or claim for worker's compensation.

In the past ten (10) years have you been treated for any of the following conditions or disorders?  
Please answer yes or no.

Broken bones, fractures or dislocations? \_\_\_\_\_ Any joint pain or injury? \_\_\_\_\_

Muscle, tendon or ligament problems? \_\_\_\_\_ Feet, ankle, or knee problems? \_\_\_\_\_

Pains, aches, numbness or weakness in the neck, shoulder, arms, hands or fingers? \_\_\_\_\_

Strains or sprains? \_\_\_\_\_ Back complaint/back injury? \_\_\_\_\_

Head injury? \_\_\_\_\_ Any other injury not mentioned? \_\_\_\_\_

For any yes answers provided in the above section, list the details in the section below.

| Accident/Injury | Details/Treatment | Begin Date | End Date |
|-----------------|-------------------|------------|----------|
|-----------------|-------------------|------------|----------|

|       |       |       |       |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Have you ever filed for Workers Compensation? \_\_\_\_\_

Are you currently receiving Workers Compensation or Disability income? \_\_\_\_\_

**Declaration**

My answers relating to my medical and employment history are true and complete to the best of my knowledge.

Full Name (Please Print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



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**WITNESS STATEMENT**

INJURED WORKER: \_\_\_\_\_

REPORT DATE: \_\_\_\_\_

CLIENT COMPANY: \_\_\_\_\_

WEATHER CONDITIONS: \_\_\_\_\_

WITNESS NAME: \_\_\_\_\_

DATE & ACCIDENT TIME: \_\_\_\_\_

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NATURE OF ACCIDENT: \_\_\_\_\_

WITNESS STATEMENT: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

POSSIBLE CAUSE OF ACCIDENT: \_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the above statement is truth, sworn by me on this \_\_\_\_\_  
day of \_\_\_\_\_ (month), \_\_\_\_\_ (year).

WITNESS SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_



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### DECLARACIÓN DE TESTIGO

Trabajador lesionado: \_\_\_\_\_ INFORME FECHA: \_\_\_\_\_

CLIENTE EMPRESA: \_\_\_\_\_ CONDICIONES CLIMÁTICAS: \_\_\_\_\_

TESTIGO NOMBRE: \_\_\_\_\_ FECHA Y ACCIDENTE TEMNE: \_\_\_\_\_

NATURALEZA DE ACCIDENTE:

\_\_\_\_\_

Declaración de un testigo: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

POSIBLE CAUSA DEL ACCIDENTE: \_\_\_\_\_

\_\_\_\_\_

A lo mejor de mi conocimiento, la declaración anterior es verdad, bajo juramento por mí en este día de \_\_\_\_\_ (mes), \_\_\_\_\_ (año).

FE DE FIRMA: \_\_\_\_\_ Fecha: \_\_\_\_\_

TELEFONO: \_\_\_\_\_



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## FORMA de EMPLEADO COMPROBACION

Verifique por favor que la informacion debajo de que usted se sometio a Howard que Arrienda S.a. sobre el empleo es correcto para que podamos comenzar a procesar reclamo de la compensacion de su trabajador y beneficios:

Nombre: \_\_\_\_\_

Direccion: \_\_\_\_\_

Telefono: \_\_\_\_\_

La fecha de Nacimiento: \_\_\_\_\_

El Numero del seguro social: \_\_\_\_\_

Firme Nombre: \_\_\_\_\_

Imprima Nombre: \_\_\_\_\_

La fecha: \_\_\_\_\_

Para beneficiarse de las prestaciones de mi reclamo de compensación del trabajador, yo \_\_\_\_\_, fe de que la información anterior es verdadera y correcta.

EMPLEADO FIRMADO NOMBRE: \_\_\_\_\_

IMPRIMA EL NOMBRE DEL EMPLEADO: \_\_\_\_\_

FECHA: \_\_\_\_\_

FE DE NOMBRE IMPRESO: \_\_\_\_\_