## STATE OF FLORIDA DIVISION OF ADMINISTRATIVE HEARINGS OFFICE OF THE JUDGES OF COMPENSATION CLAIMS

## PETITION FOR WORKERS' COMPENSATION BENEFITS

Employee/Claimant petitions the Office of the Judges of Compensation Claims for an order requiring Employer/Carrier to provide benefits due under Chapter 440, Florida Statutes as claimed below.

EMPLOYEE:	OJCC CASE NO. (required if previously issued):
ADDRESS:	or, EMPLOYEE'S SOCIAL SECURITY NO.:
TELEPHONE:	or attach a VERIFIED MOTION FOR SUBSTITUTE IDENTIFICATION NUMBER (form available on the OJCC website at www.jcc.state.fl.us)
EMPLOYER:	CARRIER:
ADDRESS:	ADDRESS:
TELEPHONE:	TELEPHONE:
CLAIMANT'S NAME (if different from the employee):	TELEPHONE NO.:
ADDRESS:	
EMPLOYEE/CLAIMANT'S ATTORNEY (if any):	
FLORIDA BAR NO.:	TELEPHONE NO.:
ADDRESS:	
DATE OF ACCIDENT (disablement date if occupational disease):	ACCIDENT COUNTY:
	ACCIDENT STATE:
DETAILED DESCRIPTION OF JOB RESPONSIBILITIES:	SPECIFIC WORK BEING PERFORMED WHEN INJURY OCCURRED:
DETAILED DESCRIPTION OF THE ACCIDENT:	IS THIS PETITION FOR MEDICAL BENEFITS ONLY (Y/N):
	AWW 13 WEEKS PRECEDING ACCIDENT:
PART(S) OF BODY INJURED:	CURRENT AWW:
	CURRENTLY WITH SAME EMPLOYER (Y/N):
	CURRENT WORK LEVEL:
	HAS MMI BEEN REACHED (Y/N): IF SO, DATE OF MMI:

1. Jurisdiction: The Judge of Compensation Claims has jurisdiction over the parties and the subject matter of this petition.

2. Managed care grievance procedures, if required, were exhausted under F.S. §440.192(3). The Grievance was dated: \_\_\_\_\_\_.

3. Character of disability. The injury/injuries occasioned by the events described above has/have adversely affected the injured employee's capacity to earn in the same or any other employment the wages that the employee was receiving at the time of the injury. Specifically, the injury prevents the injured employee from:

 Temporary Total Disability benefits from/ to/ at a specific monetary compensation rate of \$ per week.
 Temporary Partial Disability benefits from/ to/ at a specific monetary compensation rate of \$ per week.
 For accidents prior to 1994, impairment benefits due under Section 440.15(3)(a), Florida Statutes, (1979) \$ The permanent impairment due to the injury is% of the whole body.
These benefits are based on:
<ul> <li>Permanent Impairment due to total loss of use of(body part affected).</li> <li>Permanent Impairment due to amputation of, (which was amputated after July 1, 1990).</li> <li>Permanent Impairment due to the loss of 80% vision of either eye after correction.</li> <li>Serious facial injury or head disfigurement.</li> </ul>
 For accidents prior to 1994, Wage-loss benefits payable under Section 440.15(3)(b), Florida Statutes, from
/
or attach wage-loss request forms.
 Impairment benefits of \$ due under Section 440.15(3)(a)3, Florida Statutes (1994).
Supplemental benefits of \$ due under Section 440.15(3)(b), Florida Statutes (1994).
 Permanent Total Disability benefits under Section 440.15(1), Florida Statutes, from
/ to the present and continuing at a rate of \$ per week.
 Death benefits payable under Section 440.16, Florida Statutes.
 Correction of AWW and resulting Compensation Rate due to
Medical Expenses incurred for treatment of the employee's injury as provided under Section 440.13(2),
 Florida Statutes. The employee has specifically requested the payment of the charges, but the
employer/carrier has failed, refused, or neglected to do so within a reasonable amount of time.
The following medical charges have not been paid (use additional paper if necessary):
 Medical care under the supervision of Dr(s):
The employee has previously requested the treatment, but the employer/carrier has failed, refused, or neglected to provide such treatment within a reasonable time.
The injured employee seeks (type of medical treatment).
The treatment is needed because
 Medically necessary (professional/nonprofessional) attendant care as per the direction of a physician. The
employee has previously specifically requested the attendant care, but the employer/carrier has failed, refused, or neglected to provide the care within a reasonable time. The injured employee seeks attendant
care because
Physician who prescribed care: Dr Reimbursement of mileage to and from medical care providers in the amount of \$ (mileage
 statement must be attached).
 Rehabilitative Temporary Total Compensation under Section 440.491(6)(b), Florida Statutes, from/
 Interest and Penalties on unpaid benefits.
 Costs and attorney's fees from E/C under Section 440.34(3)(a)-(d), Florida Statutes.
 Reimbursement of prescription bills in the amount of \$ (see attached).
 <ul> <li>The employer/carrier/servicing agent has denied the compensability of the accident or injury.</li> <li>Other issue(s) not referenced above:</li></ul>

## Certificate of Good Faith Effort to Resolve Dispute, Acknowledgement of Fraud Statement, Certificate of Service, and Social Security Number Notice

The claimant or, if the claimant is represented by counsel, the claimant's attorney, certifies that he or she has made a good faith effort to resolve the dispute and that the claimant or attorney was unable to resolve the dispute with the employer/carrier/servicing agent.

The claimant has read and understands the following: "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." By signing below, the claimant attests that he or she has reviewed, understands, and acknowledges the foregoing notice. In accordance with Florida Statutes § 440.192(1), a copy of this petition for benefits has been served by certified mail on the injured worker's employer and the employer's carrier on \_\_\_\_\_\_. A copy of this petition has also been served on the attorney for the employer/carrier if known.

Disclosure of the employee's Social Security Number (SSN) is voluntary. An employee or claimant who does not have or declines to provide the employee's SSN must file a verified motion for assignment of substitute identification number along with the initial Petition for Benefits or Request for Assignment of Case Number in accordance with Fla. Admin. Code 60Q-6.105(4).

The employee's SSN will be used to uniquely identify the employee in the Office of the Judges of Compensation Claims (OJCC) case management system, ascertain a claimant's child support obligations before approving any lump sum settlement, and exchange information between the OJCC and the Division of Workers' Compensation. The employee's SSN may also be used by the employer and carrier named on the Petition for Benefits or Request for Assignment of Case Number to identify the employee.

SSN's are confidential and exempt from public disclosure. It is the express policy of the OJCC to prohibit the disclosure of SSN's by the OJCC or any of its employees, except the SSN will be disclosed by the OJCC for the following reasons: (1) in response to a legitimate inquiry from a state or federal agency in connection with matters within its jurisdiction; (2) if so ordered by a court of competent jurisdiction, pursuant to the terms of such order; and (3) to a commercial entity in response to a request in accordance with §119.071(5)(a)(7), Florida Statutes.

WHEREFORE, claimant requests an order directing the employer to provide the benefits as requested.

Signature of Claimant

Date

Signature of Counsel for Claimant Date

OJCC Clerk's Office PFB filing: 1180 Apalachee Parkway, Suite A, Tallahassee, Florida 32301-4574 (850) 487-1911 \* www.fljcc.org