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SECTION 1 – CONTACT INFO

Contact Us – (877) 518-2881

Sales Department
Terry Cassidy, Account Executive
terry@advancedpeo.com
sales@advancedpeo.com

Accounts Payable / Receivables Department
Frank DeMoya, Controller
frank@advancedpeo.com

Workers Comp Certificates
service@advancedpeo.com

Customer Service
Janet Odle, Payroll Manager
service@advancedpeo.com

Kelly Mullis, Operations Manager
kelly@advancedpeo.com

Technical Support
service@advancedpeo.com

Executive Team
Jeff Thompson, AAI, AIM – President
jeff@advancedpeo.com

Kelly Mullis, Operations Manager
kelly@advancedpeo.com
Company Fax: (866) 611-9598

SECTION 2 – PAYROLL

PAYROLL PROCESSING

Advanced PEO Solutions (APS) professional office staff is available to assist you with your payroll need from 8:00 a.m. to 5:00 p.m. (EST) Monday through Friday. Our main office number is (877) 518-2881.

Advanced PEO utilizes sophisticated HRMS system to process your payroll timely and efficiently giving you the peace of mind that your payroll is processed promptly, accurately, and will be delivered within our pre-arranged time frames.

In order to ensure your receipt of your payroll in a timely fashion, please submit your information on the pre-arranged submission date by the method of your choosing. Your payroll professional will communicate with you the total amount of your invoice typically within the same business day in order for you to have your funds available.

Notice of Non-Payroll Processing

If your company will not be performing or conducting **ANY** business operations; wherein your company, or employees of the company received, or will receive payments for services, or work performed during the work week, you MUST complete and submit a Notice of Non-Processing form to APS. **Failure to complete and submit this form no later than client company's normal payroll reporting date may result in client company being terminated and workers' compensation insurance being canceled.**

Please note: if payroll is not processed for three consecutive pay periods, client is subject to termination.

New Employee Forms

In this section, you will find the various APS new employee forms that are vital to begin the accurate processing of payroll for new employees

Your account manager will guide you in the importance of all of these forms and how to complete them correctly.

New Employee Packet

- Employment Application
  - Company Acknowledgement
  - Personal Data Sheet
  - W-4
  - Employee Agreement / Workers Comp Questionnaire
- Direct Deposit form (optional)

All documents must be signed in the appropriate areas by the employee to ensure that they are processed correctly. All paperwork must be submitted prior to employee start date to ensure coverage under worker's compensation.

1933 E EDGEWOOD DR SUITE 102
LAKELAND, FL 33803
1-877-518-2881
WWW.ADVANCEDPEO.COM

New Hire Submission and Return Receipt

PLEASE SUBMIT FORMS TO:

SERVICE@ADVANCEDPEO.COM **OR FAX 1-866-611-9598**

Notice to Client Company: NO Person shall be considered an employee of Advanced PEO Solutions, LLC until the "NEW HIRE" forms have been completed in full, signed, and submitted to Advanced PEO Solutions and Advanced PEO Solutions has notified your company by phone, fax, letter or email that the new hire has been verified and accepted as an employee. (Refer to Client Service Agreement for details).

It is clearly understood that no new hire will be placed in service by CLIENT COMPANY until the "NEW HIRE" applications have been received and approved by Advanced PEO Solutions. The CLIENT COMPANY also acknowledges that if CLIENT COMPANY does place such person into service for CLIENT COMPANY before receiving the required approval AND receipt from Advanced PEO Solutions, the person is NOT working under Advanced PEO Solutions' workers' compensation policy and the CLIENT COMPANY is totally and completely responsible for all liabilities and or penalties should any occur.

Co- Employers Signature of Acknowledgement: _____
(President/Owner)

***MUST Be signed before turning in payroll to Advanced PEO Solutions.**

NEW HIRE NAME: _____
(please print)

Representative of Advanced PEO Solutions LLC will sign and return

INTERNAL OFFICE USE:

Date application received: _____

Employee: ☐ Accepted ☐ Denied Reason: _____

Date Client Notified: _____ Contact Person: _____

How Notified: _____ Contact Info: _____

Authorized by Advanced PEO Solutions Rep: _____

EMPLOYEE INFORMATION

Advanced PEO Solutions, LLC (APS) is a professional employer organization, which means that APS is a co-employer of the employees working for its worksite employers/client companies. As a co-employer, APS is the employer of record for payroll, tax reporting, workers compensation insurance, claims management, and other possible administrative functions. The client company or worksite employer is responsible for the day to day work of the employees and otherwise running the client company.

EQUAL OPPORTUNITY EMPLOYER

We adhere to a policy of making employment decisions without regard to race, color, age, sex, religion, nationality, disability, handicap or marital status. If you require reasonable accommodation in completing the form, please inform us.

PERSONAL DATA

Full Name: _____ SSN#_____

Present Mailing Address: _____ City _____ ST_____Zip_____

Former Address: _____ City _____ ST_____Zip_____

Phone: _____ Cell Phone: _____ Email:_____

Type of work Desired: _____ Part Time ☐ Full Time ☐

Are you 18 years of age or older? _____ (if under 18, please state your age _____) Date of Birth: _____
(If you are under 18 years of age, employment is subject to verification that you are of legal minimum age and can furnish any required work permit)

Are you on layoff subject to recall elsewhere? _____ Explain: _____

Are you prevented from lawfully becoming employed in this country because of VISA or Immigration Status? _____

Date Available for Employment: _____ Minimum Salary Requirement:$ _____

Have you been employed here previously? _____ If yes, when? _____ Last Position Held: _____

Have you ever been convicted of a crime, entered into a plea of nolo contendre (no contest) to a crime, pled guilty to a crime, had adjudication withheld or received a suspended sentence (regardless of the ultimate adjudication) for a crime? YES ☐ NO ☐ IF YES, give details concerning the type of crime, the date of the conviction or plea, the penalty imposed, and any other circumstances you deem relevant to a full understanding of what occurred.

Have you been arrested and charged with any misdemeanor or felony not disclosed above for which you are out on bail, free on own recognizance pending disposition or trial (do not include minor traffic violations/infractions for which no court appearance is necessary)? YES ☐ NO ☐ IF YES, give the date and details of the arrest or charge and any other circumstances you deem relevant to a full understanding of what occurred.

Have you ever been sued for causing death of, or injury to any person, or damage to any property (e.g., for assault, battery, defamation, etc.)? YES ☐ NO ☐ IF YES, give details concerning the nature of the claims and defenses raised by the parties, the outcome of the action (e.g., settlement, jury verdict, or other disposition), and any other circumstances you deem relevant to a full understanding of what occurred.

NOTE: Answering yes to the three previous questions is not an automatic bar to employment. Factors such as age at the time of the offense, seriousness and nature of the violation, relatedness to the job sought, and evidence of rehabilitation will be taken into account. However, please be advised that a misstatement or omission in answering these questions may be grounds for disciplinary action, including discharge.

Number of Days Absent from Work Last Year: _____ Do you have Transportation TO and FROM Work? _____ Can you work overtime if asked? _____

PLEASE READ THE FOLLOWING STATEMENTS BEFORE SIGNING BELOW

The facts set forth in my application are true and complete. I authorize the investigation of all statements contained in this application and hereby authorize my former employers to furnish all information pertaining to my work record. I hereby release my former employers from all liability on account of furnishing such information. I understand that false statements, omissions, or misleading statements on this application shall be considered sufficient cause for refusal to hire or dismissal and I agree that my employer shall not be held liable in any respect if my employment is terminated because of such omission, or false or misleading statements. Advanced PEO Solutions, LLC is hereby authorized to investigate my employment history, including the contacting of the employers listed previously.

SIGNATURE: _____ Date: _____

PLEASE PRINT NAME AS IT APPEARS ON YOUR SOCIAL SECURITY CARD

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2014

1 Type or print your first name and middle initial.	Last name	**2 Your social security number**
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2011, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	**7**	

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form **W-4**

Instructions and worksheets for completing the W-4 furnished upon request.

Emergency Contact Name	Relationship	Phone Numbers

SECTION 2 – TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR OR MANAGER

Client Company: _____

Client Location: _____

Dept. Name or Number: _____

Date of Hire: _____

Job Title: _____

Workers Comp Class Code: _____
(If unsure of class code, contact Advance PEO Solutions)

Supervisor, Manger or
Authorized Signature: _____

Title: _____ Date: _____

Pay Cycle: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Pay Type: ___Full Time ___Part Time

Exempt ☐ Hourly ☐ Salary

Rate of Pay: $_____ per _____

Nonexempt ☐ Hourly ☐ Salary

Accurate Time Records Must Be Maintained

Rate of Pay: $_____per _____

Tipped Employees: ☐ NO ☐ YES

Shift Pay: ☐ NO ☐ YES Rate: $_____ per _____

Piecework: ☐ NO ☐ YES Rate: $_____ per _____

Commissions: ☐ NO ☐ YES Rate: $_____per _____

***Client Company is responsible for completing, verifying, and maintaining I-9 Form for every employee**

SECTION 3 – EMPLOYEE AGREEMENT

I, the undersigned employee, in consideration of my hiring by Advanced PEO Solutions, LLC (APS) as an at-will leased employee of APS, acknowledge and agree to the following:

1. I have been hired as an at-will employee of APS, which is an Employee Leasing Company, and there is no contract of employment which exists between me and the CLIENT COMPANY to which I have been assigned, nor between APS and me. I understand and agree that either APS or I can terminate our employment relationship at any time, as I am an at-will employee.
2. I also agree that while I am a leased employee of APS, if APS does not receive payment from CLIENT COMPANY for services which I perform as a leased employee, APS will still pay me the applicable minimum wage (or the legally required minimum salary or overtime pay) for any such period, and I agree to this method of compensation. I understand that the CLIENT COMPANY to which I am assigned at all times remains obligated to pay me my regular hourly rate of pay if I am a non-exempt employee and to pay me my full salary if I am an exempt employee even if APS is not paid by CLIENT COMPANY to which I am assigned.
3. In recognition of the fact that any work related injuries which might be sustained by me are covered by state workers' compensation statutes, and to avoid circumvention of such state statutes which may result from suits against customers or clients of APS or against APS based on the same injury or injuries, and the extent permitted by law, I hereby waive and forever release any rights I may have to make claims or bring suit against CLIENT COMPANY or customer of APS or against APS for damages based upon injuries which are covered under such workers' compensation statutes. I also agree to comply with any drug testing policy, which APS may adopt, and I specifically agree to post-accident drug testing in any situation where it is allowed by law. I also agree that if I am injured, unless any other leave program is applicable, I will accept any modified/light duty assignment provided to be within the scope of my physical capabilities as determined by the workers' compensation treating physician.
4. I also agree that if at any time during my employment I am subjected to any type of discrimination, including discrimination because of race, sex, age, religion, color, retaliation, veteran status, national origin, handicap, disability or marital status, or if I am subjected to any type of harassment including sexual harassment, I will immediately contact an appropriate person of the CLIENT COMPANY to which I am assigned . In most instances, this appropriate person will be the president of the CLIENT COMPANY. Should I choose not to contact the CLIENT COMPANY for any reason, I may contact APS Human Resource Director at 1-877-518-2881 in order to obtain assistance in the resolution of such matters. I understand and agree that APS does not have actual control over my workplace, and as such, is not in a position to end or remediate any discrimination, harassment, or retaliation which may be occurring. The responsibility to end such inappropriate conduct rests solely with the CLIENT COMPANY: however APS will attempt to facilitate a resolution.
5. I understand that I will receive my daily instructions from the co-employer to whom I have been assigned. There will be a 90-day probationary period at which time any party can terminate employment without further obligation.
6. As a drug and alcohol free workplace, APS prohibits , among other things, the unlawful possession , consumption, distribution, or unauthorized use by all employees of alcohol or any illegal drugs or illegally obtained drugs in the workplace or when conducting work. Nor is any employee permitted to work after having ingested illegal or illegally obtained drugs or while impaired or under the influence of alcohol or drugs. Employees can be required to submit to drug and or alcohol testing under certain circumstances in accordance with APS's drug and alcohol free workplace testing program, including post accident and reasonable suspicion testing. Any employee who violates APS's policies may be subject to immediate discharge. Questions concerning APS's drug and alcohol free policies/ testing should be directed to APS Human Resources Director at 1-877-518-2881.
7. I further agree that at the end of my assignment with the CLIENT COMPANY, ***I will report back to APS for possible reassignment to another client. If I fail to report within 48 hours, I may be denied unemployment benefits.***

By signing below, I acknowledge that I understand all of the items above. I further understand that I am an employee of Advanced PEO Solutions LLC and that Advanced PEO Solutions LLC is my employer of record.

_____ _____ _____

Employee Signature Printed Name Date

SECTION 4 – WORKERS COMPENSATION QUESTIONNAIRE

This questionnaire should not be answered unless the applicant has accepted a conditional offer of employment.

	YES	NO
1. Have you ever received treatment for a back, neck or knee condition or head injury?	☐	☐
2. Have you ever had any surgery?	☐	☐
3. Has any injury or illness ever prevented you from gainful employment?	☐	☐
4. Have you ever had an injury on the job?	☐	☐
5. Have you ever received a disability rating for any reason?	☐	☐
6. Have you ever received compensation or medical benefits under workers compensation?	☐	☐
7. Do you have any limitations which may affect your ability to safely or effectively perform the position you are offered?	☐	☐

Explain any YES answers: _____

_____

I have been fully advised that if I am injured on the job, regardless of how minor the injury, I am to report that injury immediately to my supervisor. A notice of injury must be submitted by APS to the insurance carrier within 7 days as required by law.

I further certify all answers above to be true and correct. I understand any false or misleading answers will be sufficient reason for denial of benefits under the Workers Compensation Act of my state, and will be basis for immediate termination of employment.

_____ _____ _____

Employee Signature Witness Date

Loss History Affidavit
Notice of Non-Processing

Client Name: _____ Date: _____

This letter is my official notification that the above referenced company did NOT have any work:

From _____, _____ _____, 20____

Through _____, _____ _____, 20____

I attest NO employees conducted ANY business on behalf of the above listed company and are not entitled to receive any wages, nor will they receive any none earned compensation for the referenced time period.

I further attest and affirm that because there was NO business related work or activities for the time period listed above there were NO work related accidents or injuries.

My signature below attests to the fact I understand and am aware that failure to report all hours worked and all wages and compensation is considered insurance fraud, a felony of the 3rd degree, punishable in accordance with State of Florida Insurance Laws.

Officer's signature _____ Date _____

Officer's printed name _____ Title _____

This form must be completed and presented to Advanced PEO Solutions, LLC (or its subsidiaries) for all time periods in which the client company does not process its regular scheduled payroll. Failure to complete and submit this form on or before the regular scheduled payroll will result in client termination. In all cases, failure to process a regular scheduled payroll will result in the client's worker's compensation coverage being suspended/canceled and in a pricing evaluation with potential rate increases, miscellaneous fees, and/or adjustments. NO resumption of coverage or additional payroll processing will be authorized until all workdays are accounted for through the completion of this form with notarized signature.

Advanced PEO Solutions Internal Use Only

____ Date/Time client contacted	___Fees explained to client	___Safety Coordinator's approval
____ Date/Time client faxed	___Notary requirement explained	___Original form in permanent file

ADVANCED PEO Solutions

SECTION 3 – EMPLOYEE MAINTENANCE

In this section, you will find the forms necessary to communicate to APS any changes in employee information, deductions, disciplinary actions, and employee terminations. All changes must be in writing and signed by the employee as well as the worksite supervisor.

- Employee Status Change
  - Change in pay rate
  - Change in workers comp code
  - Change of address
  - Change of telephone number
  - Change in marital status
  - Change in spouse/dependent information
  - Date of rehire
  - Date of termination

- Payroll Deduction Form
  - Please remit prior to payroll processing or with timesheet

- Disciplinary Action Record
  - Completed for both verbal and written warnings

- Employee Termination Form
  - Must be completed and sent to APS immediately to insure accurate processing of payroll
  - Previous Disciplinary Action Records (if employee is terminated with or without cause)

You can fax these forms to us at (866) 611-9598 or email to service@advancedpeo.com

ADVANCED PEO Solutions

Employee Status Change

Employee Last Name	First Name	MI	Social Security Number
Change of Address:			Change of Telephone:

W-4 Withholding Allowance Change

3. ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.

Note: If Married, but legally separated, or spouse is a nonresident alien check the Single box.

4. If you last name differs from that on your social security card, check here and call 1-800-772-1213 for more information ..... ☐

5. Total number of allowances you are claiming ..... 5. _____

6. Additional amount, if any, you want deducted from each paycheck ..... 6. _____

7. I claim exemption from withholding and I certify that I meet BOTH the following conditions of exemption:

- Last year I had a right to a refund and ALL Federal income tax withheld because I had NO tax liability; AND
- This year I expect a refund of ALL Federal income tax withheld because I expect to have NO tax liability.

If you meet BOTH conditions enter "EXEMPT" here ..... 7. _____

Employee Signature: _____ **Date:** _____

The above changes cannot be made without an employee signature.

Payroll Change

Effective Date: _____	Job Title: _____		
____ Hourly ____ Commission ____ Salaried Only ____ Salaried w/ O.T. ____ Other _____	____ Full-Time ____ Part-Time ____ Regular ____ Temporary	Pay Rate $ _____	Workers' Compensation Code _____
Description of Duties – or Attach Job Description			

Employee Separation

Termination Date _____

Voluntary (Resignation)	Involuntary (Discharge)	Inactive / Leave of Absence
____ Resigned with notice – health reasons	____ Absenteeism / Tardiness ____ Lack of Work	____ Disciplinary lay off
____ Resigned with notice – other reasons	____ Unsatisfactory work ____ Dishonesty	____ Illness (FMLA ____ Yes ____ No)
____ Resigned – no notice	____ Insubordination ____ Death	____ Maternity (FMLA ____ Yes ____ No)
____ No show / No call _____ days	____ Destruction of company property	____ Family Obligations (FMLA ____ Yes ____ No)
____ Accepted another job	____ End of Temporary assignment	____ Injury – Work Related
____ Other – please explain	____ Other – please explain	____ Personal
Comments/Explanation Would you rehire employee? ____Yes ____ No		

_____ _____

Client Representative Signature **Date**

ADVANCED
PEO Solutions

Email Form to:
sales@advancedpeo.com
Fax: 866-611-9598

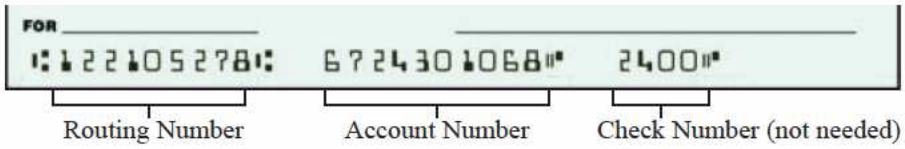
DIRECT DEPOSIT AUTHORIZATION

Name: _____ SSN: _____

Client Company Name: _____

Name of Banking Facility:	Checking: ☐ Savings: ☐
Account Number:	Dollar Amount $:
Routing Number:	Percentage:

Name of Banking Facility:	Checking: ☐ Savings: ☐
Account Number:	Dollar Amount $:
Routing Number:	Percentage:



REQUIREMENTS

Attach one of the following for **EACH** Direct Deposit (**Failure to do so will delay the processing of your direct deposit**):

1. **Checking Account:** Copy of a voided check or bank courtesy letter (no deposit slips).
2. **Savings Account:** A bank courtesy letter stating: Your Name, Routing #, and Account #.
3. The designated account(s) must be in your name.

Please read and sign before submitting: Funds transferred by electronic transmission normally post to an account in two to three business days after the payroll is processed. Employee remains responsible for verifying that the funds are deposited, clear, and available prior to writing checks or debiting account

Also, please allow one additional business day for direct deposits to be processed during a holiday.

I grant my employer the right to correct any electronic funds transfer, resulting from an erroneous overpayment, by debiting my account to the extent of such overpayment.

Please allow two weeks for initial setup. One week for any changes.

Signature: _____ Date: _____

Email Form to sales@advancedpeo.com or Fax Form to 866-611-9598

Revised 5/6/11

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee Name: _____

Social Security #: _____

In further consideration of the Agreement(s) between me and my employer, I authorize Advanced PEO Solutions, LLC to withdraw funds from my payroll check. In the event of the termination of my employment with APS, I hereby authorize APS to deduct the balance payable from my final paycheck.

$_____ _____
(Amount of Deduction) Reason for Deduction

$_____ _____
(Amount of Deduction) Reason for Deduction

$_____ _____
(Amount of Deduction) Reason for Deduction

$_____ _____
(Amount of Deduction) Reason for Deduction

_____ _____
Employee's Signature Date

_____ _____
Supervisor's Signature Date

TERMINATION REPORT

Name: _____ SSN: _____

Client Company Name: _____ Termination Date: _____

Reason for Separation or Refusal: (Please check one of the following)

☐ Voluntary (Resignation, Job Abandonment, etc.)

- Attach Letter of Resignation, if available.
- Date employee quit _____
- Was there full time work for the employee when he/she quit? ____Yes ____No
- Please give a detailed explanation of the circumstances, including any statements made by the employee at the time of termination. (Complete Explanation of Termination below.)

☐ Involuntary (Layoff, Company Termination, Death, etc.)

- Attach Warnings, if available.
- Discharged for misconduct connected with work on _____
- Describe what the worker did or failed to do which caused the discharge. Explain the specific act of misconduct; avoid general terms like "absenteeism", "violation of rules"; tell what rule was violated and why, how often employee was absent, etc. (Complete Explanation of Termination below.)

☐ 90-Day Probation

- The worker was terminated for unsatisfactory job performance during an established 90-day probationary period of which he/she was notified during the first seven workdays.

☐ Job Refusal

- Refused offer of job on _____
- Give employee's reason for refusal. (Complete Explanation of Termination below.)

Explanation of Termination: _____

_____

_____

_____

_____

(Use additional sheets if necessary)

Eligible for Rehire? _____ **Yes** _____ **No**
Insurance Coverage? _____ **Yes** _____ **No**

I certify that my statements are true and correct.

Supervisor Signature: _____ Date: _____

DISCIPLINARY ACTION RECORD

Client Company: _____

Employee Name: _____

Date: _____

Violation Date:

☐ Dishonesty
☐ Insubordination
☐ Safety Violation
☐ Tardiness
☐ Excessive Absences
☐ Fighting
☐ Poor Job Performance
☐ Other (Explain) _____
_____

Supervisor's Statement of Violation:

_____

_____

_____

_____
Supervisor's Signature

Action Taken:

☐ Verbal Warning
☐ Written Warning
☐ Suspension _____
☐ Termination of Employment (Complete Termination Form)

Employee's Statement: ☐ Employee Refused to Sign

_____

_____

_____

_____ _____
Employee's Signature Date

Reviewed by:

_____ _____
Supervisor's Signature Date

SECTION 4 – WORKERS COMPENSATION

1933 E Edgewood Dr Suite 102
Lakeland, FL 33803
Ph 877-518-2881
Fax 866-611-9598
www.advancedpeo.com

Workers Compensation Insurance Certificate Request Form

Please complete and email to sales@advancedpeo.com or fax 866-611-9598
Form is available online as well.

Your Company Name _____

Your Company Fax# _____ Phone _____

Requested by _____ Email _____

Please Issue Certificate to the Following (Certificate Holder Name):

Cert Holder: _____

Address: _____

Attn: _____ Phone _____

Fax _____ Email _____

Jobsite Location (if necessary)

Project Name _____

Address _____

Special Notes _____

Attach any forms to clarify special instructions.

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 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 ☐ AM ☐ PM

HOME ADDRESS

Street/Apt #: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)

OCCUPATION

DATE OF BIRTH _____ / _____ / _____

SEX ☐ M ☐ F

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

EMPLOYER INFORMATION

COMPANY NAME: _____

D. B. A.: _____

Street: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

DATE EMPLOYED _____ / _____ / _____

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)

Street: _____

City: _____ State: _____ Zip: _____

LOCATION # (If applicable) _____

LAST DATE EMPLOYEE WORKED _____ / _____ / _____

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: _____

City: _____ State: _____ Zip: _____

COUNTY OF ACCIDENT _____

DATE OF DEATH (If applicable) _____ / _____ / _____

AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO

RATE OF PAY ☐ HR ☐ WK
$ _____ PER ☐ DAY ☐ MO

Number of hours per day _____
Number of hours per week _____
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.
I have reviewed, understand and acknowledge the above statement.

_____ EMPLOYEE SIGNATURE (If available to sign) _____ DATE

_____ EMPLOYER SIGNATURE _____ DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL

AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CLAIMS-HANDLING ENTITY INFORMATION

☐ 1(a) Denied Case - DWC-12, Notice of Denial Attached

☐ 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached

☐ 2. Medical Only which became Lost Time Case (Complete all required information in #3)

Employee's 8TH Day of Disability _____ / _____ / _____

Entity's Knowledge of 8TH Day of Disability _____ / _____ / _____

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

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

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

Penalty Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

REMARKS:

INSURER NAME

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

INSURER CODE # | EMPLOYEE'S CLASS CODE | EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE # | **CLAIMS-HANDLING ENTITY** FILE #

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Client:	Employee:
Date of Injury:	Time of Accident: ☐ AM ☐ PM
Chain of Custody Number:	Department:

PLEASE COMPLETE ALL QUESTIONS

Is this a report only (Injured employee ***did not*** seek Medical Treatment)? ☐ Yes ☐ No
(Have employee complete refusal of treatment)
Job being performed: _____ Was this his/her regular job? ☐ Yes ☐ No

Place of Job (parking lot, garage, residential home): _____

Job Site Address (be specific):_____

How many hours was the employee on the job before the accident occurred? _____ Start Time: _____

Last full day worked before injury: _____ County of Injury: _____

Describe the accident: _____

_____

What did the employee do or fail to do that contributed to the accident? _____

_____

What body part was injured? _____ Any witnesses? ☐ Yes ☐ No Name: _____

Is this a questionable claim?	☐ Yes	☐ No
Was there a drug screen performed?	☐ Yes	☐ No
Is light duty available for this injured employee?	☐ Yes	☐ No
Will the employee lose time from work beyond medical treatment?	☐ Yes	☐ No
Was the employee cited for the accident?	☐ Yes	☐ No
Was Employee paid for the rest of the day? If no, when was last hour paid thru? _____	☐ Yes	☐ No
Did the employee willfully refuse to use a safety appliance or have prior knowledge and willfully refused to observe a safety standard or rule?	☐ Yes	☐ No

What was the name of the clinic/hospital employee went to? _____
Clinic/Hospital address and phone #: _____
How were they transported to treatment (car, ambulance)? _____ Work Status: _____
Was the accident a result of a ☐ Unsafe Act or ☐ Unsafe Condition First Day of Treatment: _____

Supervisor Name (please print): _____ Signature of Supervisor: _____

Direct Phone/Cell #: _____ Date: _____

FAX TO ADVANCED PEO CLAIMS AT (866) 611-9598

EMPLOYEE'S REPORT OF INJURY

All injuries must be reported even if treatment is not required

An employee who suffers an injury arising out of and in the course of employment shall advise his or her employer of the inquiry within 2 days after the date of our initial manifestation of the injury (**FL Ch.440.185**).

Client:	Accident Location:
Employee:	Social Security #:
Employee Address:	Home/Cell Phone:
City, State, Zip:	Job Title:
Date of Injury:	Time of Injury: AM PM
Body Part(s) Injured:	Cause of Injury:

Describe What Happened: _____

_____

_____

The following people were present and might be a witness: _____

I probably will need further medical treatment: ☐ Yes ☐ No

I, employee, the undersigned, certify that the above is a true and correct statement of fact and that I made such statements of my own free will. I understand that any payments to me or anyone else for expenses in connection with my accident and resulting injury is not an admission of liability on the part of **Advanced PEO Solutions, LLC**. I authorize full access to copies of medical records, radiology reports, drug/alcohol screenings, and documents of any kind relating to my past or present injury/illness to **Advanced PEO Solutions, LLC**. I hereby agree to release this information and hold all such medical providers harmless for the release of this information as set forth in this authorization.
"Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

_____ _____

Signature of Employee Date Printed Name of Supervisor Date

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 or claim contacting any false or misleading information is guilty of a felony of the third degree.

DRUG TESTING – An employer may test an employee or job applicant for any drug ("Drug" means alcohol, including a distilled spirit, wine, a malt beverage, or an intoxicating liquor; an amphetamine; a cannabinoid; cocaine; phencylclidine (PCP; a hallucinogen; methaqalone; an opiate; a barbiturate; a benzodiazepine; a synthetic narcotic; a designer drug; or a metabolite of any of the substances listed in this paragraph. An employer may test an individual for any or all of such drugs) and deny medical and indemnity benefits under this chapter. (FL. Ch.440.102)

Fax to Advanced PEO Solutions at (866) 611-9598

WITNESS STATEMENT

Client:	Accident Location:
Witness Name:	Home Phone:
City, State, Zip:	Job Title:
Name of Injured Worker:	Are you related to the injured worker? ☐ Yes ☐ No
Date of Injury:	Time of Injury: AM/PM
Body Part(s) Injured:	Cause of Injury:

Was the accident a result of ☐ An Unsafe Act or ☐ An Unsafe Condition?

Was the injured employee wearing any safety equipment (e.g. goggles, gloves, back braces, hearing protection)? ☐ Yes ☐ No

Describe what happened, in detail, what you saw or know regarding this incident:

_____

_____

_____

List names of any other persons who may have information regarding this:

_____

_____

Is there any other information that you know that would assist in providing a fair evaluation of this incident?

_____

_____

_____

_____

Signature of Witness _____ Date _____

Fax to Advanced PEO Solutions at (866) 611-9598

Temporary Prescription Services ID

Important Benefit Information

Attention Injured Employee:

The attached injured employee prescription instructions identify you as a member of AWPRx Program. It is important when filling prescriptions that you present this Temporary Prescriptions Services ID form to your pharmacist before obtaining your prescription. If you have any questions about your injured employee drug program or to locate a participating pharmacy, please contact Customer Service toll-free at **800-600-1930**.

ATTENTION PHARMACIST: The Vendor ID is AWPRX (888) 700-3392. *Advanced PEO Solutions, LLC insured by Guarantee Insurance Company Policy #: GPEO543000001-111*

Mailing Address:
160 North Westmonte Drive
Altamonte Springs, FL 32714

Toll Free Phone: 800-600-1930
Toll Free Fax: 888-700-7997

This form will help you get your prescriptions filled today rather than waiting on an ID card. Please note that this card is temporary that you will indeed receive a new on in the mail at your mailing address on file. If you do not receive one within five (5) business days, please contact our claims department at (877) 518-2881 during normal business hours. Our business hours are Monday through Friday 8:00 a.m. – 5:00 p.m., Eastern Standard Time.

SECTION 5 – FAMILY AND MEDICAL LEAVE ACT (FMLA)

Family and Medical Leave Act (FMLA)

Family and Medical Leave Act (FMLA)

For employees with at least 12 months of service who have worked at least 1250 hours, leave for childbirth, adoption of a child or a serious health condition of the employee or this/her immediate family member (spouse, child, parent) will be granted without pay for up to a maximum of 12 weeks in any 12 month period. For purposes of this policy, the 12 month period shall be the 12 month period measure backwards form the date an employee last used any FMLA.

Intermittent leave for child birth or adoption will not normally be granted. All leave granted under this section will be counted against an employee's annual family and medical leave entitlement.

Employees must provide 30 days advance notice of any foreseeable leave request under this provision. If 30 days' notice is not practical, such as in the case of a medical emergency, leave should be requested as soon as practical.

To request a leave for a serious health condition, the employee will be required to submit a certification from a medical doctor (or other appropriate health care provider) stating:

- The date on which the serious health condition began
- The probable duration of the condition
- The appropriate medical facts within the knowledge of the health care prodder regarding the condition, and
- For a serious health condition of an employee's family member, a statement that the employee is needed to care for that family member and an estimate of the amount of time needed for the employee to care for the family member, or
- Fort eh employees' own health condition, a statement that the employee is unable to perform the essential job functions of his/her position, or
- If intermittent leave for medical treatment is requested, the dates and duration of such treatment.

When leave for a serious medical condition is foreseeable, employees must provide such medical certification within 15 calendar days of their leave request unless it is not practical under the particular circumstances to do so despite their diligent good faith efforts. If an employee fails to provide such timely certification, the leave request may be denied until a reasonable period after the required certification is provided. When such a leave is not foreseeable, an employee must provide a medical certification within a reasonable time may result in denial of the continuation of the employee's leave.

Although benefits will not accumulate during any leave, benefits accumulated before leave will not affected except that Advanced PEO Solutions, LLC may require that any

accumulated paid vacation, paid sick leave and/or paid leave days be exhausted during and in conjunction with FMLA leave.

Employees who take leave under this policy due to their own serious health condition will normally be required to provide a fitness-for-duty certification from their health care provider stating they are able to resume the essential function of the job. Whether such a certification will be required will depend upon the nature of the illness and the duration of the absence and will be required in all cases where job safety to the employee and other must be determined.

Upon return from a family or medical leave, an employee will be returned to the same or an equivalent position unless the employee fails to provide a required fitness-for-duty medical certification or is a key employee whose reinstatement would cause substantial and grievous economic injury to the operations of Advanced PEO Solutions or its clients. For the purposes of this policy, a key employee is defined as a salaried employee eligible for leave under this policy whose pay is amount the top 10% of all APS employees within a 75 mile radius of the employee's worksite.

Employees who do not qualify under the above family or medical leave service requirements or who have exhausted family or medical leave under this section may also request leave for family or medical reasons in advance with the provisions governing personal leave. Also, as to family and medical leaves, Advanced PEO Solutions specifically reserves all rights available to employers under the Family and Medical Leave Act of 1993, including the right to obtain a second opinion form a physician of its own choosing even if those rights are no specifically referenced in this policy.

Termination of Leave

An employee will be considered as having resigned his or her position if he or she:

1. Fails to return to work on the first day after his or her leave of absence or an authorized extension expires

2. Applies for or engages in any other employment during his or her leave of absence unless the employee received prior written permission from Advanced PEO Solutions; or

3. Gives a false reason for any requested leave of absence.

4. Takes leave without appropriate authorization or medical certification.

If you have any questions concerning FMLA please contact Advanced PEO Solutions, LLC.