FLORIDA DEPARTMENT OF FINANCE SERVICES
DIVISION OF WORKERS' COMPENSATION
OFFICE OF SPECIAL DISABILITY TRUST FUND
200 East Gaines Street
Tallahassee, Florida 32399-4223

PREFERRED WORKER REIMBURSEMENT REQUEST

SDTF RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE NAME	SDTF CLAIM NUMBER	DATE OF ACCIDENT
EMPLOYER NAME	EMPLOYER/FEIN NUMBER	DATE OF HIRE
HOURLY RATE OF PAY	CLASS CODE	SIC CODE

THE FOLLOWING MUST BE ATTACHED:

1) UCT-6 (OR OTHER ACCEPTABLE DOCUMENTATION OF PAYROLL AND JOB CLASSIFICATION FILED WITH THE DIVISION OF UNEMPLOYMENT COMPENSATION FOR ALL QUARTERS FOR WHICH REIMBURSEMENT IS REQUESTED).

2) COPY OF THE PREMIUM CALCULATION SHEET.

3) COPY OF THE PREMIUM AUDIT.

PERIOD FOR WHICH REIMBURSEMENT IS REQUESTED FROM: TO:	TOTAL AMOUNT REIMBUREMENT REQUESTED
TOTAL REIMBURSED PRIOR TO THIS REQUEST	
NAME AND ADDRESS OF PAYEE:	COMMENTS:
PAYEE'S FEDERAL TAX I.D. NUMBER:	
MAIL CHECK TO:	

I HEREBY CERTIFY THAT ALL SUMS LISTED ON THIS FORM HAVE BEEN PAID.

PREPARER'S SIGNATURE:	SIGNED BY:	EMPLOYER NAME, ADDRESS & TELEPHONE
PREPARER'S TYPED NAME:	TITLE:	
PREPARER'S TELEPHONE NUMBER:	DATE:	

NOTE: This report **MUST BE SIGNED** by the employer or his duly authorized agent or carrier. **SUPPORTING RECORDS** are subject to audit by the Division of Workers' Compensation. The signed original and one copy **MUST BE FILED WITH THE FUND** by the employer requesting reimbursement.

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.

Form DFS-F1-PW-2 (Rev. 1/31/2008)