THE DEPARTMENT OF FINANCIAL SERVICES
Division of the State Fire Marshal

FIREFIGHTERS SUPPLEMENTAL COMPENSATION PROGRAM
QUARTERLY REPORT
BUREAU OF FIRE STANDARDS & TRAINING

QUARTER: ☐ 1ST (JAN-MAR) ☐ 2ND (APR-JUN) ☐ 3RD (JUL-SEP) ☐ 4TH (OCT-DEC) YEAR _____

NAME OF FIRE DEPARTMENT/EMPLOYING AGENCY

FIRE CHIEF/AUTHORIZED AGENT | DEPARTMENT TELEPHONE #

DEPARTMENT MAILING ADDRESS | CITY | STATE | ZIP CODE

NOTE: This form must be submitted within 10 business days of last day of quarter.
The following information must be in alphabetical order and typed or printed legibly.

	FIREFIGHTER'S NAME	LAST 4 DIGITS OF SOCIAL SECURITY NUMBER[1]	AMOUNT PAID
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

TOTAL AMOUNT PAID THIS QUARTER: _____ This is page _____ of _____ pages

I hereby certify that the above listed individuals have received the amounts indicated.

SIGNATURE OF CHIEF OR AUTHORIZED AGENT | POSITION | DATE

Submit this form to the:
Bureau of Fire Standards & Training, 11655 NW Gainesville Road, Ocala, Florida 34482-1486

[1] **USE OF SOCIAL SECURITY NUMBERS: Applicant's last four digits of the social security numbers are used by the Division of State Fire Marshal for identification purposes, to prevent misidentification, and to facilitate the approval process by the Division. The Department of Financial Services, Division of State Fire Marshal, will not disclose an applicant's last four digits of the social security number, without consent of the applicant, to anyone outside of the state agencies of Florida, except as required by law.**