PERMANENT TOTAL SUPPLEMENTAL WORKSHEET

SENT TO DIVISION DATE	DIVISION RECEIVED DATE

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

200 East Gaines Street
Tallahassee, FL 32399-4224

PLEASE PRINT OR TYPE

EMPLOYEE NAME, ADDRESS & TELEPHONE #:	DATE OF ACCIDENT: (Month-Day-Year)	SOCIAL SECURITY #:
	GUARDIAN, If applicable	DATE OF BIRTH: (Month-Day-Year)

PT ACCEPTANCE/ADJUDICATION DATE: _____ ☐ CARRIER PAY ☐ DIVISION PAY

COMPUTATION OF SUPPLEMENTAL WEEKLY COMPENSATION

AWW: $_____

STEP 1: A. $_____ **Enter employee's compensation rate in accordance with the Law in effect on the date of accident.**

B. x $_____ **Amount of 5% supplemental authorized (3% for dates of accident on or after October 1, 2003)**

C. = $_____ **Basic Weekly Increase**

D. x $ _____ **Number of CALENDAR years since the date of accident**

- **Subtract year of accident from year of PT Acceptance/Adjudication**

E. = $_____ **Total weekly supplemental – Enter below in (A1)**

STEP 2: A. $_____ **(Enter the figure from STEP 1A)**

B. + $_____ **(Enter the figure form STEP 1E)**

C. = $_____ **(TOTAL – cannot exceed maximum for appropriate year)**

THE MAXIMUM WEEKLY COMPENSATION RATE:

1. $_____ **per week, beginning** _____ **4. $**_____ **per week, beginning** _____

2. $_____ **per week, beginning** _____ **5. $**_____ **per week, beginning** _____

3. $_____ **per week, beginning** _____ **6. $**_____ **per week, beginning** _____

STEP 3: Weekly supplemental divided by; 7 x total number of days in year. Combine yearly amounts to get total initial payment due to claimant.

(A1) Weekly Supplemental Rate	Beginning Date (MM/DD/YY)	Ending Date (MM/DD/YY)	(B1) Total Number of Days	(C1) Total Amount (A1 divided by 7 x B1 = C1)	Comments (if any)

TOTAL INITIAL PAYMENT $_____

First Regular Payment Amount $_____ **Payment Date** _____

(Weekly Amount x 4 = Division Pay) **(Weekly Amount x 2 = Carrier Pay)**

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.

INSURER CODE	ADJUSTER NAME:	INSURER NAME: CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE
SERVICE CO./TPA CODE #	DATE PREPARED: (Month-Day-Year)	

DWC-35 Purpose and Use Statement

The collection of the social security number on this form is imperative for the Division of Workers' Compensation's performance of its duties and responsibilities as prescribed by law. 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.