

**Ken Lawson**, Secretary

**Rick Scott**, Governor

**FLORIDA FARM LABOR REGISTRATION AND TESTING  
WORKERS' COMPENSATION INFORMATION**  
(Workers' Compensation Coverage Provided by Contractor's Employer)

\_\_\_\_\_  
Name of Contractor/Corporation

\_\_\_\_\_  
Social Security or License Number

\_\_\_\_\_  
Street, Rural Route or Post Office Box

\_\_\_\_\_  
City, State and Zip Code

Effective this date \_\_\_\_\_, I, \_\_\_\_\_

\_\_\_\_\_  
NAME, ADDRESS, AND PHONE NUMBER OF EMPLOYER

will pay the premium for Workers' Compensation Insurance on you and your crew members as long as you are in our employment. **I understand that this coverage will also be used to cover the transportation of workers.**

Our policy number is \_\_\_\_\_. The policy period is from \_\_\_\_\_ to \_\_\_\_\_.

Your employment with us should last until approximately \_\_\_\_\_.

Must be a specific date (MM/DD/YY)

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Title of Signer

***TO BE COMPLETED BY THE INSURANCE CARRIER OR CARRIER'S DULY AUTHORIZED AGENT***

I HEREBY CERTIFY THE ABOVE STATEMENT IS CORRECT, AND THAT THE POLICY COVERS THE TRANSPORTATION OF WORKERS.

\_\_\_\_\_  
Name of Insurance Agency

\_\_\_\_\_  
Signature of Insurance Representative

\_\_\_\_\_  
Street Address or Post Office Box

\_\_\_\_\_  
Date

\_\_\_\_\_  
City, State and Zip Code