



State of Florida, Division of Administrative Hearings
Office of the Judges of Compensation Claims
 1203 Governors Square Boulevard, 6th Floor, Tallahassee Florida 32301 (850) 487-1911

**VERIFIED MOTION FOR ASSIGNMENT OF
 SUBSTITUTE IDENTIFICATION NUMBER**

INSTRUCTIONS: Fill this form in completely, sign it in the presence of a commissioned notary, show identification to the notary, and submit this completed form along with your Petition for Benefits or Request for Assignment of Case Number.

1. Employee's name _____ 2. Employee's date of birth _____

3. Employee's current or last known address _____

4. I do not have, or I decline to provide, my/employee's Social Security Number.

WHEREFORE, the claimant requests that the Office of the Judges of Compensation Claims obtain and assign a substitute identification number from the Division of Workers' Compensation. By signing below, I swear or affirm, under penalties of perjury, that the facts stated on this document are true and accurate.

Claimant's Signature _____

Country of _____, State of _____, County of _____

The foregoing document was acknowledged before me this ____ day of _____, 20____, by _____, who is personally known to me or who has produced identification and who took an oath/affirmed.

The Identification Presented to the Notary Public is _____

Signature of Notary Public _____

(Notary Public Seal) Name of Notary Public _____

My commission expires _____

This section must be completed by the notary if documentary identification is unavailable.

Statement of Reason for Unavailability of Documentary Identification: _____

Basis of Personal Knowledge of the Affiant: _____