BEFORE THE
STATE OF FLORIDA
COMMISSION ON ETHICS

In re ROBERT COLLINS,	)	Financial Disclosure Appeal No. FD 20-032
	)	
Appellant.	)	Final Order No.
	)	

FINAL ORDER

This matter came before the Commission on Ethics, meeting in public session on April 22, 2022, on the timely appeal of Appellant, pursuant to Section 112.3145(8)(g), Florida Statutes, which assesses an automatic fine of $25 per day on a person who fails to timely file a required CE Form 1, Statement of Financial Interests. The Commission may waive the fine in whole or in part for good cause shown, based on "unusual circumstances" surrounding the failure to file by the designated date. There are no matters in dispute. Appellant did not request a hearing before the Commission.

Findings of Fact

1. According to information provided to the Commission, Appellant served as a Planner IV for the Bureau of Preparedness within the Florida Division of Emergency Management, a position that requires the filing of a CE Form 1, Statement of Financial Interests, for the year 2019. The designated due date for submitting a 2019 CE Form 1 annual filing was July 1, 2020, with a grace period ending on September 1, 2020.

2. No later than May 19, 2020, the Commission mailed the Appellant a notice regarding the financial disclosure filing requirement, the filing deadline, and providing the Appellant with a blank 2019 CE Form 1. The notice was mailed to the Appellant at 2555 Shumard Oak Blvd., Tallahassee FL 32399-7018.

3. No later than July 31, 2020, the Commission sent Appellant a delinquency notice via certified mail advising him of the financial disclosure filing deadline and of the penalties that could be imposed should he fail to file financial disclosure by the September 1, 2020, deadline. The notice was mailed to Appellant at the 2555 Shumard Oak address.

4. On August 20, 2020, the Commission mailed Appellant a courtesy postcard reminding him of the financial disclosure filing obligation and of the deadline for filing. The notice was mailed to Appellant at the 2555 Shumard Oak address.

5. On September 8, 2020, the Commission mailed Appellant a Courtesy Notice of Fines Accruing. The notice was mailed to Appellant at the 2555 Shumard Oak address.

6. On September 21, 2020, the Appellant filed his 2019 CE Form 1, twenty (20) days late from the September 1, 2020 deadline.

7. On March 16, 2021, the Commission mailed Appellant a Notice of Assessment of Automatic Fine wherein the Commission advised the Appellant that an automatic fine in the amount of $500 had been assessed against him and apprised the Appellant of the manner in which to appeal.

8. On April 15, 2021, the Commission received a timely Appeal of Automatic Fine for the Form Year 2019 submitted by the Appellant. In part B of his appeal form, the Appellant checked "Sickness or injury" as the general reason for the appeal. In part C of the appeal form, where an appellant is asked to provide a detailed explanation of his or her appeal including why the option they selected in part B of their form is applicable to their situation, the Appellant stated that on May 6, 2020, he suffered a workplace injury to his dominant right shoulder/arm. The Appellant further stated that, on July 14, 2020, he had surgery on his right arm/shoulder (for a Type III, Rotator Cuff Surgical Procedure) and was placed in prolonged rehabilitation and

recovery until September 17, 2020. In support of his appeal, the Appellant attached a detailed letter explaining his injury and voluminous medical records including the worker's compensation application filed with the state, the initial visitation records, his MRI reports, records and pictures of the Rotator Cuff Surgical Procedure, follow-up visitation records, and his working hours timesheets for August, 2020 through September, 2020 tabulating his sick leave and leave without pay (LWOP) following the surgical procedure. Essentially, the records provided by the Appellant span from the date of the injury, i.e., May 6, 2020, through his last day of being on sick leave and leave without pay (LWOP), i.e., September 17, 2020.

Conclusions of Law

8. The Commission has jurisdiction over the subject matter of this proceeding pursuant to Section 112.3145, Florida Statutes.

9. Financial disclosure is required of public officials and employees because it enables the public to evaluate potential conflicts of interest, deters corruption, and increases public confidence in government.

10. Section 112.3145(8)(g), Florida Statutes, states:

> Any reporting person may appeal or dispute a fine, based upon unusual circumstances surrounding the failure to file on the designated due date, and may request and is entitled to a hearing before the commission, which may waive the fine in whole or in part for good cause shown. Any such request must be in writing and received by the commission within 30 days after the notice of payment due is transmitted. In such a case, the reporting person must, within the 30-day period, notify the person designated to review the timeliness of reports in writing of his or her intention to bring the matter before the commission. For purposes of this subparagraph, the term "unusual circumstances" does not include the failure to monitor an e-mail account or failure to receive notice if the person has not notified the commission of a change in his or her e-mail address.

11. The basis for the appeal of the fine — that the Appellant suffered an unforeseen workplace injury that necessitated a surgery and consequential rehabilitation during the 2019 CE Form 1 notification and filing period — constitutes an "unusual circumstance" that justifies waiving the $500 fine.

Order

Based on the foregoing facts and conclusions of law, the Commission hereby waives the assessed fine of $500.

ORDERED by the State of Florida Commission on Ethics meeting in public session on Friday, April 22, 2022.

Date Rendered

John Grant
Chair, Florida Commission on Ethics

THIS ORDER CONSTITUTES FINAL AGENCY ACTION. ANY PARTY WHO IS ADVERSELY AFFECTED BY THIS ORDER HAS THE RIGHT TO SEEK JUDICIAL REVIEW UNDER SECTION 120.68, AND SECTION 112.3241, FLORIDA STATUTES, BY FILING A NOTICE OF ADMINISTRATIVE APPEAL PURSUANT TO RULE 9.110 FLORIDA RULES OF APPELLATE PROCEDURE, WITH THE CLERK OF THE COMMISSION ON ETHICS, AT EITHER 325 JOHN KNOX ROAD, BUILDING E, SUITE 200, TALLAHASSEE, FLORIDA 32303 OR P.O. DRAWER 15709, TALLAHASSEE, FLORIDA 32317-5709; AND BY FILING A COPY OF THE NOTICE OF APPEAL ATTACHED TO WHICH IS A CONFORMED COPY OF THE ORDER DESIGNATED IN THE NOTICE OF APPEAL ACCOMPANIED BY THE APPLICABLE FILING FEES WITH THE APPROPRIATE DISTRICT COURT OF APPEAL. THE NOTICE OF ADMINISTRATIVE APPEAL MUST BE FILED WITHIN 30 DAYS OF THE DATE THIS ORDER IS RENDERED.

JG: sc

Mr. Robert R. Collins
1806 Gibbs Dr.
Tallahassee, FL 32303.

283002 20-032

HAND DELIVERED

FLORIDA COMMISSION ON ETHICS
APR 15 2021
RECEIVED

STATE OF FLORIDA
COMMISSION ON ETHICS

325 John Knox Road
Building E, Suite 200
Tallahassee, FL 32303
Telephone: (850) 488-7864
Fax: (850) 488-3077
Email: disclosure@leg.state.fl.us

APPEAL OF AUTOMATIC FINE FOR FORM YEAR 2019

DIRECTIONS: The information you provide in this form is critical for processing your appeal in a timely manner.

In Part A, please provide current contact information. If your contact information changes while your appeal is being processed, please notify us.

In Part B, please check any boxes that specify the general reason(s) for your appeal.

In Part C, please explain in detail the reason(s) for your appeal. In addition to your written explanation in Part C, you may attach any documents that support your appeal.

IMPORTANT: TO PRESERVE YOUR RIGHT TO APPEAL, THIS FORM OR OTHER WRITTEN APPEAL (AND ANY ATTACHMENTS) MUST BE FILED WITH (RECEIVED BY) THE COMMISSION ON ETHICS WITHIN THIRTY (30) DAYS OF THE DATE THE NOTICE OF ASSESSMENT OF AUTOMATIC FINE WAS MAILED TO YOU.

PLEASE SEND YOUR COMPLETED FORM TO ONE OF THE FOLLOWING:

Mailing Address: Commission on Ethics
P.O. Drawer 15709
Tallahassee, FL 32317-5709

Physical Address: Commission on Ethics
325 John Knox Road
Building E, Suite 200
Tallahassee, FL 32303

Fax: (850) 488-3077

Email: disclosure@leg.state.fl.us

PART A: YOUR INFORMATION

Name: Robert R. Collins

Address: 1806 Gibbs Dr City: Tallahassee State: FL Zip: 32303

Daytime Tel.: 850 815 4336 Cell: 850-766-2494

Email: robert.collins@em.myflorida.com Filer ID# (if known): 283002

Public Employer: FL Division of Emergency Management

Public Position: Planner IV, Bureau of Preparedness

CONTINUED ON REVERSE SIDE

PART B: GENERAL REASON(S) FOR YOUR APPEAL

Please choose any/all reasons that apply to your appeal.

I hereby appeal the Notice of Assessment of Automatic Fine on the following basis:

a. [✓] **Sickness or injury** (Explain in Part C and attach a statement from attending physician, including dates and nature of illness or injury)

b. [ ] **Lack of notification – Failure to receive notice** (Explain in Part C and provide documentation that supports your assertion that you never received certified mail delinquency notice: for example, incorrect address; misdelivered mail; change in employment; extended absence from home, etc.)

c. [ ] **Claim of timely filing of financial disclosure** (Explain in Part C and provide copy of certified mail receipt and/or copy of completed form which had been previously filed, along with a sworn notarized statement that you filed prior to the deadline)

d. [ ] **Left public position prior to December 31, 2019** (Explain in Part C and provide confirmation from agency that your office-holding/employment ended before 12/31/2019)

e. [ ] **Other unusual circumstance** (Explain in Part C and provide documentation explaining uncommon, rare, or sudden occurrence that prevented timely filing prior to deadline)

f. [ ] **Not required to file** (Explain in Part C and provide documentation that supports reason for not required to file)

PART C: DETAILED EXPLANATION OF YOUR APPEAL

Please provide a detailed explanation of your appeal, including why each option you selected in Part B is applicable to you. You may use the space provided and/or attach additional pages.

Type III Rotator Cuff (Shoulder) of right arm surgery on 8-14-2020 with recovery period until 9-17. Work performed under Workers Compensation (FL) to repair and rehabilitate right shoulder rotator cuff tear that occurred outside State Emergency Operations center during COVID-19 response.

OPTIONAL REQUEST FOR HEARING

[ ] In addition to this written appeal, I specifically request to appear before the Commission in a hearing pursuant to Section 112.3144(8)(f)3 or Section 112.3145(8)(g)3, Florida Statutes. Commission meetings occur in Tallahassee.

SIGNATURE

I have received and read the Notice of Assessment of Automatic Fine and its instructions on How to Appeal and I understand my options. I am requesting disposition of this matter as indicated.

4-15-2021
DATE

Rett R Cole
SIGNATURE

SEE ATTACHED EXPLANATION LETTER & SUPPORTING DOCUMENTATION

Robert R. Collins
Florida Division of Emergency Management
2555 Shumard Oak Boulevard
Tallahassee, Florida 32399
Tel (w) 850-815-4336, (c) 850-766-2494
robert.collins@em.myflorida.com
Filer ID#: 283002
Public Employer: Florida Division of Emergency Management
Public Position: Planner IV, Bureau of Preparedness

APRIL 15, 2021

State of Florida, Commission on Ethics
325 John Knox Road
Building E, Suite 200
Tallahassee, Florida 32303

I would like to appeal the $500 assessed fine for the late filing due to exigent and unexpected medical circumstances, as well as my having limited access to my office to receive routine mailing. During the entire financial disclosure filing period:

- I was seeking medical treatment for a work-related injury that resulted in a worker's compensation claim;
- The required surgery to repair the injury occurred near the submission deadline;
- Due to recovery from that surgery, I could not physically or reasonably prepare the filing documents until the date I filed, which was after the suspense date; and
- I was activated in the State Emergency Operations Center (SEOC) from the end of February, 2020, to the day before the scheduled surgery as part of the State Emergency Response Team (SERT) for the COVID-19 pandemic.

Furthermore, as a Planner IV for the Florida Division of Emergency Management (FDEM), my annual gross income for 2020 was $43,737.90, and this fine constitutes a greater than 1.5% reduction of my take home pay. I believe the amount of this levy will impose an undue financial hardship on my family. I am providing the following justifications and documentation for my request.

On May 6th, 2020, in the midst of the state's response to the COVID-19 pandemic, for which I had been activated in the SEOC since February 29th, 2020, I injured my right shoulder at work on a broken piece of curb outside of the Rudd Building (site of the SEOC). The shoulder of my dominant arm, the right, was injured when I fell on it. FDEM's Personnel Department, both of whom were at the scene immediately after the incident, referred me to the Jet Medical Clinic as the initial step of a worker's compensation claim.

The Jet Medical Clinic (see attached files) initially prescribed a regimen of Physical Therapy (PT), steroid injections and a muscle relaxant to address the injury. In addition to weekly visits to the Jet Clinic (see

attached) to assess the progress of my recovery, I participated in twice-weekly PT sessions for May and a portion of June.

On June 12th on the order of the Physician Assistant at Jet Medical Clinic, because the PT and other medical measures to alleviate the injury did not seem to bring any lasting relief, referred me to have an MRI, done on my shoulder which was performed on June 15th. The MRI report (see attached) disclosed severe damage (tears to three of the four muscles) to the rotator cuff of the right arm, which would require medical intervention in order to permanently remedy the problem. I was referred to Dr. Peter Loeb of the North Florida Sports Medicine and Orthopedic Center to have surgery on my torn rotator cuff.

Dr. Loeb performed the surgery on August 14th as scheduled, the pictures of which are provided with this letter as documentation. The procedure was successful, although more complicated and took longer than Dr. Loeb expected. At the initial post-operative meeting on 8/25, Dr. Loeb characterized the rotator cuff procedure as a Type III repair (see the report from 10/15/2020), which is the most severe classification for this type of shoulder surgery.

During the entire period of February 29th to the day before the surgery on August 13th, I was activated for the COVID-19 pandemic response in the SEOC and only went to my normal office very rarely. Most of the FDEM staff not activated for the COVID-19 response or in the SEOC was working remotely from home and the Sadowski Building, where my office was located, was a restricted access area as a protective measure for the pandemic. In addition, during the entire month of April, I was also working the COVID-19 activation at an alternate SEOC site which also effectively barred my access to my routine work office.

Given the severity of the damage, recovery was very painful with the arm in a restrictive sling for over a month. Dr. Loeb after assessing the surgery on August 25th, recommended no work for 3 weeks afterward (see attached Worker's Comp Uniform Medical Treatment/Status Reporting Form for that date) for which I was on worker's compensation leave (see attached People's First timesheets). The pain and the restrictive nature of the sling did not allow me to use any writing implement, or the ability to easily type on a computer keyboard. Any attempt to move the right arm post-surgery resulted in spasms and extreme pain; it was very easy to comply with the Dr. Loeb's order to limit any and all activity with that arm. I was not scheduled and did not return to Dr. Loeb for another post-operative appointment until September 17th.

On September after assessing my progress he recommended that I could return to light duty and that it was OK to be on a computer. I filed the required ethics form on Monday, September 21 upon checking my work e-mails remotely and learning of the deadline to file the disclosure form on September 1st.

Regards,

Robert R. Collins

Planner IV,
Florida Division of Emergency Management, Bureau of Preparedness

FORM 1 STATEMENT OF FINANCIAL INTERESTS 2019

FOR OFFICE USE ONLY:

9-21-20
Processed

Division of Emergency Management-Employees

**********AUTO**5-DIGIT 32399 T13 P1 4 2881

ROBERT RUSSELL COLLINS, Planner IV
2555 SHUMARD OAK BLVD
TALLAHASSEE FL 32399-7018

ID CODE

ID NO. 283002

CONF. CODE

Collins, Robert Russell

CHECK ONLY IF ☐ CANDIDATE OR ☐ NEW EMPLOYEE OR APPOINTEE

****** THIS SECTION MUST BE COMPLETED ******

DISCLOSURE PERIOD:

THIS STATEMENT REFLECTS YOUR FINANCIAL INTERESTS FOR CALENDAR YEAR ENDING DECEMBER 31, 2019.

MANNER OF CALCULATING REPORTABLE INTERESTS:

FILERS HAVE THE OPTION OF USING REPORTING THRESHOLDS THAT ARE ABSOLUTE DOLLAR VALUES, WHICH REQUIRES FEWER CALCULATIONS, OR USING COMPARATIVE THRESHOLDS, WHICH ARE USUALLY BASED ON PERCENTAGE VALUES (see instructions for further details). CHECK THE ONE YOU ARE USING **(must check one)**:

☐ **COMPARATIVE (PERCENTAGE) THRESHOLDS** OR ☑ **DOLLAR VALUE THRESHOLDS**

PART A -- PRIMARY SOURCES OF INCOME [Major sources of income to the reporting person - See instructions]
(If you have nothing to report, write "none" or "n/a")

NAME OF SOURCE OF INCOME	SOURCE'S ADDRESS	DESCRIPTION OF THE SOURCE'S PRINCIPAL BUSINESS ACTIVITY
NONE		

PART B -- SECONDARY SOURCES OF INCOME
[Major customers, clients, and other sources of income to businesses owned by the reporting person - See instructions]
(If you have nothing to report, write "none" or "n/a")

NAME OF BUSINESS ENTITY	NAME OF MAJOR SOURCES OF BUSINESS' INCOME	ADDRESS OF SOURCE	PRINCIPAL BUSINESS ACTIVITY OF SOURCE
NONE			

PART C -- REAL PROPERTY [Land, buildings owned by the reporting person - See instructions]
(If you have nothing to report, write "none" or "n/a")

NONE

You are not limited to the space on the lines on this form. Attach additional sheets, if necessary.

FILING INSTRUCTIONS for when and where to file this form are located at the bottom of page 2.

INSTRUCTIONS on who must file this form and how to fill it out begin on page 3.

PART D — INTANGIBLE PERSONAL PROPERTY [Stocks, bonds, certificates of deposit, etc. - See instructions]
(If you have nothing to report, write "none" or "n/a")

TYPE OF INTANGIBLE	BUSINESS ENTITY TO WHICH THE PROPERTY RELATES
401k	Vanguard - Atkins/SNC Lavalin
State of FL Deferred Comp	Nationwide

PART E — LIABILITIES [Major debts - See instructions]
(If you have nothing to report, write "none" or "n/a")

NAME OF CREDITOR	ADDRESS OF CREDITOR
First FL Credit Union/ TruHome Solutions	PO Box 14908, Lenexa, KS 66285-4908

PART F — INTERESTS IN SPECIFIED BUSINESSES [Ownership or positions in certain types of businesses - See instructions]
(If you have nothing to report, write "none" or "n/a")

	BUSINESS ENTITY # 1	BUSINESS ENTITY # 2
NAME OF BUSINESS ENTITY		
ADDRESS OF BUSINESS ENTITY		
PRINCIPAL BUSINESS ACTIVITY		
POSITION HELD WITH ENTITY		
I OWN MORE THAN A 5% INTEREST IN THE BUSINESS		
NATURE OF MY OWNERSHIP INTEREST		

PART G — TRAINING
For **elected municipal officers** required to complete annual ethics training pursuant to section 112.3142, F.S.

☐ **I CERTIFY THAT I HAVE COMPLETED THE REQUIRED TRAINING.**

IF ANY OF PARTS A THROUGH G ARE CONTINUED ON A SEPARATE SHEET, PLEASE CHECK HERE ☐

SIGNATURE OF FILER:

Signature:

Robert D. Coll

Date Signed:

9-21-2020

CPA or ATTORNEY SIGNATURE ONLY

If a certified public accountant licensed under Chapter 473, or attorney in good standing with the Florida Bar prepared this form for you, he or she must complete the following statement:

I, _____, prepared the CE Form 1 in accordance with Section 112.3145, Florida Statutes, and the instructions to the form. Upon my reasonable knowledge and belief, the disclosure herein is true and correct.

CPA/Attorney Signature: _____

Date Signed: _____

FILING INSTRUCTIONS:

If you were mailed the form by the Commission on Ethics or a County Supervisor of Elections for your annual disclosure filing, return the form to that location. To determine what category your position falls under, see page 3 of instructions.

Local officers/employees file with the Supervisor of Elections of the county in which they permanently reside. (If you do not permanently reside in Florida, file with the Supervisor of the county where your agency has its headquarters.) Form 1 filers who file with the Supervisor of Elections may file by mail or email. Contact your Supervisor of Elections for the mailing address or email address to use. Do not email your form to the Commission on Ethics, it will be returned.

State officers **or** ***specified state employees*** who file with the Commission on Ethics may file by mail or email. To file by mail, send the completed form to P.O. Drawer 15709, Tallahassee, FL 32317-5709; physical address: 325 John Knox Rd, Bldg E, Ste 200, Tallahassee, FL 32303. To file with the Commission by email, scan your completed form and any attachments as a pdf (do not use any other format), send it to CEForm1@leg.state.fl.us and retain a copy for your records. Do not file by both mail and email. Choose only one filing method. Form 6s will not be accepted via email.

Candidates file this form together with their filing papers.

MULTIPLE FILING UNNECESSARY: A candidate who files a Form 1 with a qualifying officer is not required to file with the Commission or Supervisor of Elections.

WHEN TO FILE: ***Initially***, each local officer/employee, state officer, and specified state employee must file ***within 30 days*** of the date of his or her appointment or of the beginning of employment. Appointees who must be confirmed by the Senate must file prior to confirmation, even if that is less than 30 days from the date of their appointment.

Candidates must file at the same time they file their qualifying papers.

Thereafter, file by July 1 following each calendar year in which they hold their positions.

Finally, file a final disclosure form (Form 1F) within 60 days of leaving office or employment. Filing a CE Form 1F (Final Statement of Financial Interests) does not relieve the filer of filing a CE Form 1 if the filer was in his or her position on December 31, 2019.

Mail Piece Details

Print this page

Recipient Address

ROBERT RUSSELL COLLINS
2555 SHUMARD OAK BLVD
TALLAHASSEE, FL 32399-7018

Record / Case Number:
283002

Return Address

STATE OF FLORIDA
COMMISSION ON ETHICS
PO DRAWER 15709
TALLAHASSEE, FL 32317-5709

Entry Point ZIP:
32317

Mail Piece Information

Tracking Number: 9214890106615400015307051 2
Date Created: 07/30/2020 04:04:16 PM
Mail Class: USPS First Class Mail
Special Services: Certified Mail
Return Receipt Electronic
Memo: --
Created By: Kimberly Holmes - Commission on Ethics

Tracking Information

Mailed, July 30, 2020, 04:04:16 PM, TALLAHASSEE,FL 32317
Pre-Shipment Info Sent To Usps, Usps Awaiting Item, July 30, 2020, 12:00:00 AM
Pre-Shipment Info Sent Usps Awaits Item, July 30, 2020, 03:21:00 PM, TALLAHASSEE,FL 32317
Accepted At Usps Origin Facility, July 31, 2020, 07:14:00 PM, TALLAHASSEE,FL 32317
Origin Acceptance, July 31, 2020, 07:14:00 PM, TALLAHASSEE,FL 32317
Arrived At Usps Regional Facility, July 31, 2020, 08:29:00 PM
Processed Through Usps Facility, July 31, 2020, 08:29:00 PM, TALLAHASSEE,FL 32301
Departed Usps Regional Facility, July 31, 2020, 11:12:00 PM
Depart Usps Facility, July 31, 2020, 11:12:00 PM, TALLAHASSEE,FL 32301
In Transit, Arriving On Time, August 01, 2020, 12:00:00 AM
Departed Usps Regional Facility, August 02, 2020, 12:38:00 AM
Processed Through Usps Facility, August 02, 2020, 12:38:00 AM, TALLAHASSEE,FL 32301
In Transit, Arriving Late, August 03, 2020, 12:00:00 AM
In Transit, Arriving Late, August 04, 2020, 12:00:00 AM
In Transit, Arriving Late, August 05, 2020, 12:00:00 AM
In Transit, Arriving Late, August 06, 2020, 12:00:00 AM

BEFORE THE
STATE OF FLORIDA
COMMISSION ON ETHICS

In re **Robert Russell Collins** **PID#: 283002**
Planner IV
Employees
Division of Emergency Management

NOTICE OF ASSESSMENT OF AUTOMATIC FINE

The Commission on Ethics hereby gives notice of an assessment of a fine against you pursuant to Section 112.3145(8)(g), Florida Statutes, due to your failure to timely file your 2019 CE Form 1, Statement Of Financial Interests. Under the law, your 2019 CE Form 1, Statement of Financial Interests, was due by July 1, 2020. The law provided for a penalty-free grace period extending the due date to September 1, 2020. After that date, you accrued fines of $25.00 per day for each day your financial disclosure was late, pursuant to Section 112.3145(8)(g),Florida Statutes.

Inasmuch as your 2019 CE Form 1 was filed September 21, 2020 with the Commission on Ethics, you are fined the amount of $500.00 ($25.00 per day for 20 day(s) late). This fine must be paid to the Commission on Ethics within 30 days of the date of this notice unless you appeal the fine to the Commission. The Commission has the authority to consider the appeal and waive the fine in whole or in part if your failure to file on time was due to "unusual circumstances" surrounding the failure to file.

HOW TO APPEAL

1. Read these instructions carefully before submitting your appeal.
2. **LEGAL AUTHORITY:** Appeals are governed by Section 112.3145(8)(g)3.,Florida Statutes, and Commission Rule 34-8.215, Florida Administrative Code.
3. **FORMAT:** Your appeal must be in writing and mailed to Florida Commission on Ethics, P. O. Drawer 15709, Tallahassee, FL 32317-5709, or delivered to Florida Commission on Ethics, 325 John Knox Road, Building E, Suite 200, Tallahassee, FL 32303. The appeal may take the form of a letter or you may use the appeal form included in this mailing. The appeal form also is available at the Commission's website: www.ethics.state.fl.us. Click on "Financial Disclosure" and then the link to the sample appeal form.
4. **DUE DATE:** Your appeal must be received by the Commission on Ethics on or before **April 15, 2021.** NOTE: Failure to timely file an appeal will constitute a waiver of your right to appeal and will result in the entry of a default order against you.
5. **UNUSUAL CIRCUMSTANCES:** An appeal must demonstrate that you submitted your CE Form 1 after the extended due date because of "unusual circumstances." "Unusual circumstances" is defined in Commission Rule 34-8.215(4), Florida Administrative Code, as "uncommon, rare, or sudden events over which the reporting individual had no control and which directly result in the failure to act in accordance with the filing requirements." Therefore, circumstances that allowed for time to take steps necessary to file on time do not constitute "unusual circumstances" that will allow the Commission to waive the fine. You have the burden to establish "unusual circumstances." Your appeal must specifically state the circumstances that led to your not filing by September 1, 2020, and must include any documentation or evidence supporting your appeal, such as:
   a. **SICKNESS/INJURY:** a statement from attending physician, including dates and nature of the illness or injury;
   b. **LACK OF NOTICE (WRONG ADDRESS):** documentation that you did not reside at the address to which notice was sent;
   c. **LACK OF NOTICE (ABSENCE FROM HOME):** documentation establishing the period of time of your absence covering the notification period;

d. **CLAIM OF TIMELY FILING OF FINANCIAL DISCLOSURE:** (1) an affidavit from you attesting under oath or affirmation that you filed your financial disclosure and your recollection of when and how you filed and (2) a copy of a certified mail receipt and/or a copy of the completed form which was filed. If you have witnesses to your filing, we also will need an affidavit from each witness. NOTE: A claim of having filed the CE Form 1F for the current year does not satisfy the CE Form 1 filing requirement or excuse a late filing;

e. **LEFT PUBLIC POSITION BEFORE DECEMBER 31, 2019:** confirmation of your last date of office or employment by your former agency, showing the last date to be before December 31, 2019; or

f. **UNCLAIMED CERTIFIED MAIL**: if deliquency notice was addressed correctly but not received, you must explain why.

6. **YOUR RIGHT TO A HEARING:** You have the right to have your appeal heard by the Commission and to appear before the Commission at the hearing, but, to exercise this right, you must specifically request a hearing in your appeal. If you do not request a hearing, you will waive your right to a hearing, the Commission will determine the outcome of your appeal based upon the written record (including the documentation you provide and any documentation in your case file), and you will receive no further notice until after the Commission decides your appeal.

FAILURE TO PAY FINE OR FILE APPEAL WITHIN 30 DAYS

If you do not timely file an appeal or pay the assessed fine within 30 days of this Notice, a default order will be entered against you and the Commission will take the steps provided by law to collect the fine, including:

- Referral to the CFO of the Department of Financial Services, if you are a salaried state officer or employee, for withholding of a portion of you salary until the fine is satisfied; or
- Referral to your agency's governing body for withholding of a portion of your salary until the fine is satisfied;
- Referral to a collection agency, which can seek garnishment of your wages; and/or
- An additional civil penalty, not limited by this automatic fine, may be imposed if your disclosure statement is filed more than 60 days late and a complaint is filed against you pursuant to Section 112.324, Florida Statutes.

Please contact our office if you have any questions about this matter.

CERTIFICATE OF MAILING

I certify that a copy of the foregoing Notice of Assessment of Automatic Fine was furnished to:

Robert Russell Collins
2555 Shumard Oak Blvd
Tallahassee, FL 32399 -7018

by Certified Mail on this Tuesday, March 16, 2021.

KIMBERLY R. HOLMES
Program Administrator

Florida Commission on Ethics
P. O. Drawer 15709
Tallahassee, FL 32317-5709

-or-

Florida Commission on Ethics
325 John Knox Road, Building E, Ste. 200
Tallahassee, FL 32303

Tel.: (850) 488-7864
Fax: (850) 488-3077
Email: disclosure@leg.state.fl.us

Mail Piece Details

Print this page

Recipient Address

ROBERT RUSSELL COLLINS
2555 SHUMARD OAK BLVD
TALLAHASSEE, FL 32399-7018

Record / Case Number:
283002

Return Address

STATE OF FLORIDA
COMMISSION ON ETHICS
PO DRAWER 15709
TALLAHASSEE, FL 32317-5709

Entry Point ZIP:
32317

Mail Piece Information

Tracking Number: 9214890106615400016086366 4
Date Created: 03/16/2021 04:50:01 PM
Mail Class: USPS First Class Mail
Special Services: Certified Mail
Return Receipt Electronic
Memo: --
Created By: Kimberly Holmes - Commission on Ethics

Signature Information

Signed For By: P MCWHITE
Signature Status: Available (Click Here)

Having issues viewing the signature file?
Make sure you are using the latest version of Adobe Acrobat Reader

Tracking Information

Mailed, March 16, 2021, 04:50:01 PM, TALLAHASSEE,FL 32317
Pre-Shipment Info Sent To Usps, Usps Awaiting Item, March 16, 2021, 12:00:00 AM
Pre-Shipment Info Sent Usps Awaits Item, March 16, 2021, 04:02:00 PM, TALLAHASSEE,FL 32317
Accepted At Usps Origin Facility, March 18, 2021, 07:34:00 AM, TALLAHASSEE,FL 32317
Origin Acceptance, March 18, 2021, 07:34:00 AM, TALLAHASSEE,FL 32317
Arrived At Usps Regional Facility, March 18, 2021, 08:49:00 AM
Processed Through Usps Facility, March 18, 2021, 08:49:00 AM, TALLAHASSEE,FL 32301
Departed Usps Regional Facility, March 18, 2021, 11:22:00 PM
Depart Usps Facility, March 18, 2021, 11:22:00 PM, TALLAHASSEE,FL 32301
In Transit, Arriving On Time, March 19, 2021, 12:00:00 AM
In Transit, Arriving On Time, March 20, 2021, 12:00:00 AM
In Transit, Arriving On Time, March 21, 2021, 12:00:00 AM
In Transit To Next Facility, March 22, 2021, 12:00:00 AM
Arrived At Post Office, March 23, 2021, 05:06:00 AM, TALLAHASSEE,FL 32301
Arrival At Unit, March 23, 2021, 05:06:00 AM, TALLAHASSEE,FL 32301
Available For Pickup, March 23, 2021, 05:46:00 AM, TALLAHASSEE,FL 32399
Delivered Front Desk/Reception/Mail Room, March 23, 2021, 09:49:00 AM, TALLAHASSEE,FL 32311

UNITED STATES POSTAL SERVICE

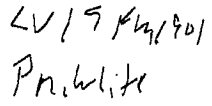
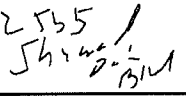
March 24, 2021

Dear MAIL MAIL:

The following is in response to your request for proof of delivery on your item with the tracking number: **9214 8901 0661 5400 0160 8636 64**.

Item Details	
Status:	Delivered, Front Desk/Reception/Mail Room
Status Date / Time:	March 23, 2021, 9:49 am
Location:	TALLAHASSEE, FL 32311
Postal Product:	First-Class Mail®
Extra Services:	Certified Mail™
	Return Receipt Electronic
Recipient Name:	ROBERT RUSSELL COLLINS

Recipient Signature

Signature of Recipient:	
Address of Recipient:	

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Sincerely,
United States Postal Service®
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The customer reference information shown below is not validated or endorsed by the United States Postal Service. It is solely for customer use.

Reference ID: 9214890106615400016086366 4
283002
ROBERT RUSSELL COLLINS
2555 Shumard Oak Blvd
Tallahassee, FL 32399-7018

1ST FOLLOW UP, DR LOEB, 8-25-2020 PG 1

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1

BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3

NOTE: Health care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.

1. Insurer Name: AMERISYS	2. Visit/Review Date: 08 / 25 / 2020	5. FOR INSURER USE ONLY
3. Injured Employee (Patient) Name: ROBERT COLLINS	4. Date of Birth: 11 / 19 / 1958	
6. Date of Accident: 05 / 06 / 2020	7. Employer Name	8. Initial visit with this physician? ☒ a) NO ☐ b) YES

SECTION I CLINICAL ASSESSMENT / DETERMINATIONS

9. ☐ No change in Items 9 – 13d since last reported visit. If checked, GO TO SECTION II.

10. Injury/ Illness for which treatment is sought is:
☐ a) NOT WORK RELATED ☐ b) WORK RELATED ☐ c) UNDETERMINED as of this date

11. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable.
☐ a) NO ☐ b) YES ☐ c) UNDETERMINED as of this date
If YES or UNDETERMINED, explain: ____

12. Diagnosis(es): ____ S/P RC Repair.

13. Major Contributing Cause: When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 11.
a) Is there a pre-existing condition contributing to the current medical disorder?
☐ a_1) NO ☐ a_2) YES ☐ a_3) UNDETERMINED as of this date
b) Do the objective relevant medical findings identified in Item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition?
☐ b_1) NO ☐ b_2) exacerbation ☐ b_3) aggravation ☐ b_4) UNDETERMINED as of this date
c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?
☐ c_1) NO ☐ c_2) YES
d) Given your responses to the Items above, is the injury/illness in question the major contributing cause for:
☐ d_1) NO ☐ d_2) YES the reported medical condition?
☐ d_3) NO ☐ d_4) YES the treatment recommended (management/treatment plan)?
☐ d_5) NO ☐ d_6) YES the functional limitations and restrictions determined?

SECTION II PATIENT CLASSIFICATION LEVEL

☑ 14. LEVEL I - Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment correlates to the specific findings.

☐ 15. LEVEL II - Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance, and Motor control. Treatment: physical reconditioning and functional restoration.

☐ 16. LEVEL III -Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.

☐ 17. LEVEL UNDETERMINED AS OF THIS DATE.

SECTION III MANAGEMENT / TREATMENT PLAN

☐ 18. No clinical services indicated at this time. If checked, GO TO SECTION IV

☐ 19. No change in Items 20a – 20g since last report submitted. If checked, GO TO SECTION IV

20. The following proposed, subsequent clinical service(s) is/are deemed medically necessary.
*** THIS IS A PROVIDER'S WRITTEN REQUEST FOR INSURER AUTHORIZATION OF TREATMENT OR SERVICES. ***

☐ a) Consultation with or referral to a specialist. Identify principal physician: ____
Identify specialty & provide rationale: ____
☐ a_1) CONSULT ONLY ☐ a_2) REFERRAL & CO-MANAGE ☐ a_3) TRANSFER CARE

☐ b) Diagnostic Testing: (Specify) ____

☐ c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:
☐ c_1) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.
☐ c_2) Physical Reconditioning (Level II Patient Classification)
☐ c_3) Interdisciplinary Rehabilitation Program (Level III Patient Classification)
Specific instruction(s): ____ Cont Rehab.

☐ d) Pharmaceutical(s) (specify): ____

☐ e) DME or Medical Supplies: ____

☐ f) Surgical Intervention - specify procedure(s): ____
☐ f_1) In-Office: ____
☐ f_2) Surgical Facility: ____
☐ f_3) Injectable(s) (e.g. pain management): ____

☐ g) Attendant Care: ____

1ST FOLLOW UP, DR. LOEB, 8-25-2020 PG 2

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 2

Patient Name: ROBERT COLLINS	D/A: 05 / 06 / 2020	Visit/Review Date: 08 / 25 / 2020

SECTION IV FUNCTIONAL LIMITATIONS AND RESTRICTIONS

Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status related to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.

☐ 21. No functional limitations identified or restrictions prescribed as of the following date: __/__/____.

☑ 22. The injured workers' functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of the following date: __/__/____. *Use additional sheet if needed.*

☐ 23. The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient. Identify joint and/or body part ____. Use additional sheet if needed.

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
☐ Bend			
☐ Carry			
☐ Climb			
☐ Grasp			
☐ Kneel			
☐ Lift-floor > waist			
☐ Lift-waist>overhead			
☐ Pull			
☐ Push		Off Work	
☐ Reach – overhead			
☐ Sit		x 3 weeks.	
☐ Squat			
☐ Stand			
☐ Twist			
☐ Walk			
☐			
☐ Other			
COMMENTS:			

Other choices; Skin Contact/ Exposure; Sensory; Hand Dexterity; Cognitive; Crawl; Vision; Drive/Operate Heavy Equipment; Environmental Conditions: heat, cold, working at heights, vibration; Auditory; Specific Job Task(s); etc.

NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date.
Specify those functional limitations and restrictions, in Item 23, which are permanent if MMI / PIR have been assigned in Item 24.

SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING

24. Patient has achieved maximum medical improvement?
☐ a) YES, Date: __/__/____ ☑ b) NO ☐ c) Anticipated MMI date: __/__/____
☐ d) Anticipated MMI date cannot be determined at this time. Future Medical Care Anticipated: ☐ e) YES ☐ f) No
☐ Comments: ____

25. ___% Permanent Impairment Rating (body as a whole) Body part/system: ____

26. Guide used for calculation of Permanent Impairment Rating (based on date of accident - see instructions):
☐ a) 1996 FL Uniform PIR Schedule ☐ b) Other, specify: ____

27. Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?
☐ a) YES ☐ b) NO ☐ c) Undetermined at this time.

SECTION VI FOLLOW-UP

28. Next Scheduled Appointment Date & Time: 9/10/2020 11:10 a.m.

SECTION VII ATTESTATION STATEMENT

"As the Physician, I hereby attest that all responses herein have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

"I certify to any MMI / PIR information provided in this form."

Physician Group: North Florida Sports Medicine **Date:** 08 / 25 / 2020

Physician Signature: _____ **Physician DOH License #:** 59656

Physician Name: Peter E. Loeb,M.D. **Physician Specialty:** Orthopaedic

(print name)

If any direct billable services for this visit were rendered by a provider other than a physician, please complete sections below:

"I hereby attest that all responses herein relating to services I rendered have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

Provider Signature: _____ **Provider DOH License #:** PA9101256

Provider Name: Mark L. Marcewicz PA-C. **Date:** 08 / 25 / 2020

(print name)

Arrived- 1130 Departed- 1250

2ND FOLLOW UP, 9-17-2020, DR. LOEB PG 1

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1

BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3

NOTE: Health care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.

1. Insurer Name: AMERISYS	2. Visit/Review Date: 09 / 17 / 2020	5. FOR INSURER USE ONLY
3. Injured Employee (Patient) Name: ROBERT COLLINS	4. Date of Birth: 11 / 19 / 1958	
6. Date of Accident: 05 / 06 / 2020	7. Employer Name	8. Initial visit with this physician? ☒ a) NO ☐ b) YES

SECTION I CLINICAL ASSESSMENT / DETERMINATIONS

9. ☐ No change in Items 9 – 13d since last reported visit. If checked, GO TO SECTION II.

10. Injury/ illness for which treatment is sought is:
☐ a) NOT WORK RELATED ☒ b) WORK RELATED ☐ c) UNDETERMINED as of this date

11. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable.
☐ a) NO ☐ b) YES ☐ c) UNDETERMINED as of this date
If YES or UNDETERMINED, explain: _____

12. Diagnosis(es): _____
STROKE Injury.

13. *Major Contributing Cause:* When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 11.
a) Is there a pre-existing condition contributing to the current medical disorder?
☐ a_1) NO ☐ a_2) YES ☐ a_3) UNDETERMINED as of this date
b) Do the objective relevant medical findings identified in Item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition?
☐ b_1) NO ☐ b_2) exacerbation ☐ b_3) aggravation ☐ b_4) UNDETERMINED as of this date
c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?
☐ c_1) NO ☐ c_2) YES
d) Given your responses to the items above, is the injury/illness in question the major contributing cause for:
☐ d_1) NO ☐ d_2) YES *the reported medical condition?*
☐ d_3) NO ☐ d_4) YES the treatment recommended (management/treatment plan)?
☐ d_5) NO ☐ d_6) YES the functional limitations and restrictions determined?

SECTION II PATIENT CLASSIFICATION LEVEL

☐ 14. LEVEL I - Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment correlates to the specific findings.

☐ 15. LEVEL II - Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance, and Motor control. Treatment: physical reconditioning and functional restoration.

☐ 16. LEVEL III -Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.

☐ 17. LEVEL UNDETERMINED AS OF THIS DATE.

SECTION III MANAGEMENT / TREATMENT PLAN

☐ 18. No clinical services indicated at this time. If checked, GO TO SECTION IV

☐ 19. No change in Items 20a – 20g since last report submitted. If checked, GO TO SECTION IV

20. The following proposed, subsequent clinical service(s) is/are deemed medically necessary.
*** THIS IS A PROVIDER'S WRITTEN REQUEST FOR INSURER AUTHORIZATION OF TREATMENT OR SERVICES. ***

☐ a) Consultation with or referral to a specialist. Identify principal physician: _____
Identify specialty & provide rationale: _____
☐ a_1) CONSULT ONLY ☐ a_2) REFERRAL & CO-MANAGE ☐ a_3) TRANSFER CARE

☐ b) Diagnostic Testing: (Specify) _____

☐ c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:
☐ c_1) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.
☐ c_2) Physical Reconditioning (Level II Patient Classification)
☐ c_3) Interdisciplinary Rehabilitation Program (Level III Patient Classification)
Specific instruction(s): _____ Cont Rehab

☐ d) Pharmaceutical(s) (specify): _____

☐ e) DME or Medical Supplies: _____

☐ f) Surgical Intervention - specify procedure(s): _____
☐ f_1) In-Office: _____
☐ f_2) Surgical Facility: _____
☐ f_3) Injectable(s) (e.g. pain management): _____

☐ g) Attendant Care: _____

2ND FOLLOW UP, DR. LOEB, 9-17-2020 PG 2

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 2

Patient Name: ROBERT COLLINS	D/A: 05 / 06 / 2020	Visit/Review Date: 09 / 17 / 2020

SECTION IV FUNCTIONAL LIMITATIONS AND RESTRICTIONS

Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status related to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.

☐ 21. No functional limitations identified or restrictions prescribed as of the following date: __/__/____.

☐ 22. The injured workers' functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of the following date: __/__/____. *Use additional sheet if needed.*

☑ 23. The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient. Identify joint and/or body part _____. Use additional sheet if needed.

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
☐ Bend			
☐ Carry			
☐ Climb			
☐ Grasp			
☐ Kneel			
☐ Lift-floor > waist			
☐ Lift-waist>overhead			
☐ Pull			
☐ Push			
☐ Reach – overhead			
☐ Sit			
☐ Squat			
☐ Stand			
☐ Twist			
☐ Walk			
☐			
☐ Other			

Light Duty No Lifting Down to be in a Capacity.

COMMENTS:

Other choices; Skin Contact/ Exposure; Sensory; Hand Dexterity; Cognitive; Crawl; Vision; Drive/Operate Heavy Equipment; Environmental Conditions: heat, cold, working at heights, vibration; Auditory; Specific Job Task(s); etc.

NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date.
Specify those functional limitations and restrictions, in Item 23, which are permanent if MMI / PIR have been assigned in Item 24.

SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING

24. Patient has achieved maximum medical improvement?
☐ a) YES, Date: __/__/____ ☒ b) NO ☐ c) Anticipated MMI date: __/__/____
☐ d) Anticipated MMI date cannot be determined at this time. Future Medical Care Anticipated: ☐ e) YES ☐ f) No
☐ Comments: _____

25. ___% Permanent Impairment Rating (body as a whole) Body part/system: _____

26. Guide used for calculation of Permanent Impairment Rating (based on date of accident - see instructions):
☐ a) 1996 FL Uniform PIR Schedule ☐ b) Other, specify: _____

27. Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?
☐ a) YES ☐ b) NO ☐ c) Undetermined at this time.

SECTION VI FOLLOW-UP

28. Next Scheduled Appointment Date & Time: 10/15/2020 9:10 a.m.

SECTION VII ATTESTATION STATEMENT

"As the Physician, I hereby attest that all responses herein have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

"I certify to any MMI / PIR information provided in this form."

Physician Group: North Florida Sports Medicine

Date: 09 / 17 / 2020

Physician Signature: _____

Physician DOH License #: 59656

Physician Name: Peter E. Loeb,M.D. (print name)

Physician Specialty: Orthopaedic

If any direct billable services for this visit were rendered by a provider other than a physician, please complete sections below:

"I hereby attest that all responses herein relating to services I rendered have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

Provider Signature: _____

Provider DOH License #: PA9101256

Provider Name: Mark L. Marcewicz PA-C. (print name)

Date: 09 / 17 / 2020

Arrived - 1016 Departed - 1042

3RD FOLLOW UP, DR. LOEB, 10-15-2020 PG 1

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1

BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3

NOTE: Health care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.

1. Insurer Name: AMERISYS	2. Visit/Review Date: 10 / 15 / 2020	5. FOR INSURER USE ONLY
3. Injured Employee (Patient) Name: ROBERT COLLINS	4. Date of Birth: 11 / 19 / 1958	
6. Date of Accident: 05 / 06 / 2020	7. Employer Name	8. Initial visit with this physician? ☒ a) NO ☐ b) YES

SECTION I CLINICAL ASSESSMENT / DETERMINATIONS

9. ☑ No change in Items 9 – 13d since last reported visit. If checked, GO TO SECTION II.

10. Injury/ illness for which treatment is sought is:
☐ a) NOT WORK RELATED ☑ b) WORK RELATED ☐ c) UNDETERMINED as of this date

11. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable.
☐ a) NO ☑ b) YES ☐ c) UNDETERMINED as of this date
If YES or UNDETERMINED, explain: _____

12. Diagnosis(es): _____
S/P Type III Repair RC.

13. Major Contributing Cause: When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 11.
a) Is there a pre-existing condition contributing to the current medical disorder?
☐ a_1) NO ☐ a_2) YES ☐ a_3) UNDETERMINED as of this date
b) Do the objective relevant medical findings identified in Item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition?
☐ b_1) NO ☐ b_2) exacerbation ☐ b_3) aggravation ☐ b_4) UNDETERMINED as of this date
c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?
☐ c_1) NO ☐ c_2) YES
d) Given your responses to the Items above, is the injury/illness in question the major contributing cause for:
☐ d_1) NO ☐ d_2) YES the reported medical condition?
☐ d_3) NO ☐ d_4) YES the treatment recommended (management/treatment plan)?
☐ d_5) NO ☐ d_6) YES the functional limitations and restrictions determined?

SECTION II PATIENT CLASSIFICATION LEVEL

☑ 14. LEVEL I - Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment correlates to the specific findings.

☐ 15. LEVEL II - Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance, and Motor control. Treatment: physical reconditioning and functional restoration.

☐ 16. LEVEL III -Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.

☐ 17. LEVEL UNDETERMINED AS OF THIS DATE.

SECTION III MANAGEMENT / TREATMENT PLAN

☐ 18. No clinical services indicated at this time. If checked, GO TO SECTION IV

☐ 19. No change in Items 20a – 20g since last report submitted. If checked, GO TO SECTION IV

20. The following proposed, subsequent clinical service(s) is/are deemed medically necessary.
*** THIS IS A PROVIDER'S WRITTEN REQUEST FOR INSURER AUTHORIZATION OF TREATMENT OR SERVICES. ***

☐ a) Consultation with or referral to a specialist. Identify principal physician: _____
Identify specialty & provide rationale: _____
☐ a_1) CONSULT ONLY ☐ a_2) REFERRAL & CO-MANAGE ☐ a_3) TRANSFER CARE

☐ b) Diagnostic Testing: (Specify) _____

☒ c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:
☐ c_1) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.
☐ c_2) Physical Reconditioning (Level II Patient Classification)
☐ c_3) Interdisciplinary Rehabilitation Program (Level III Patient Classification)
Specific instruction(s): _____
Cont Therapy / Protocol,

☐ d) Pharmaceutical(s) (specify): _____

☐ e) DME or Medical Supplies: _____

☐ f) Surgical Intervention - specify procedure(s): _____
☐ f_1) In-Office: _____
☐ f_2) Surgical Facility: _____
☐ f_3) Injectable(s) (e.g. pain management): _____

☐ g) Attendant Care: _____

3RD FOLLOW UP, DR. LOEB, 10-15-2020, PG 2

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 2

Patient Name: ROBERT COLLINS	D/A: 05 / 06 / 2020	Visit/Review Date: 10 / 15 / 2020

SECTION IV FUNCTIONAL LIMITATIONS AND RESTRICTIONS

Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status related to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.

☑ **21.** No functional limitations identified or restrictions prescribed as of the following date: ___/___/___.

☐ **22.** The injured workers' functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of the following date: ___/___/___. ***Use additional sheet if needed.***

☐ **23.** The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient. Identify joint and/or body part ____. Use additional sheet if needed.

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
☐ Bend			
☐ Carry			
☐ Climb			
☐ Grasp			
☐ Kneel			
☐ Lift-floor > waist			
☐ Lift-waist>overhead			
☐ Pull			
☐ Push			
☐ Reach – overhead			
☐ Sit			
☐ Squat			
☐ Stand			
☐ Twist			
☐ Walk			
☐			
☐ Other			
COMMENTS:			

Other choices; Skin Contact/ Exposure; Sensory; Hand Dexterity; Cognitive; Crawl; Vision; Drive/Operate Heavy Equipment; Environmental Conditions: heat, cold, working at heights, vibration; Auditory; Specific Job Task(s); etc.

NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date.
Specify those functional limitations and restrictions, in Item 23, which are permanent if MMI / PIR have been assigned in Item 24.

SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING

24. Patient has achieved maximum medical improvement?
☐ a) YES, Date: ___/___/___ ☑ b) NO ☐ c) Anticipated MMI date: ___/___/___
☐ d) Anticipated MMI date cannot be determined at this time. Future Medical Care Anticipated: ☐ e) YES ☐ f) No
☐ Comments: ____

25. ___% Permanent Impairment Rating (body as a whole) Body part/system: ____

26. Guide used for calculation of Permanent Impairment Rating (based on date of accident - see instructions):
☐ a) 1996 FL Uniform PIR Schedule ☐ b) Other, specify: ____

27. Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?
☐ a) YES ☐ b) NO ☐ c) Undetermined at this time.

SECTION VI FOLLOW-UP

28. Next Scheduled Appointment Date & Time: 11/12/2020 8:40 a.m.

SECTION VII ATTESTATION STATEMENT

"As the Physician, I hereby attest that all responses herein have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

"I certify to any MMI / PIR information provided in this form."

Physician Group: North Florida Sports Medicine

Date: 10 / 15 / 2020

Physician Signature: _____

Physician DOH License #: 59656

Physician Name: Peter E. Loeb,M.D. (print name)

Physician Specialty: Orthopaedic

If any direct billable services for this visit were rendered by a provider other than a physician, please complete sections below:

"I hereby attest that all responses herein relating to services I rendered have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

Provider Signature: _____

Provider DOH License #: PA9101256

Provider Name: Mark L. Marcewicz PA-C. (print name)

Date: 10 / 15 / 2020

Arrived – 0915 Departed – 0954

LAST FOLLOW UP DR. LOEB, 11-12-2020 PG 1

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1

BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3

NOTE: Health care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.

1. Insurer Name: AMERISYS	2. Visit/Review Date: 11 / 12 / 2020	5. FOR INSURER USE ONLY
3. Injured Employee (Patient) Name: ROBERT COLLINS	4. Date of Birth: 11 / 19 / 1958	
6. Date of Accident: 05 / 06 / 2020	7. Employer Name	8. Initial visit with this physician? ☒ a) NO ☐ b) YES

SECTION I CLINICAL ASSESSMENT / DETERMINATIONS

9. ☐ No change in Items 9 – 13d since last reported visit. If checked, GO TO SECTION II.

10. Injury/ Illness for which treatment is sought is:
☐ a) NOT WORK RELATED ☑ b) WORK RELATED ☐ c) UNDETERMINED as of this date

11. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable.
☐ a) NO ☑ b) YES ☐ c) UNDETERMINED as of this date
If YES or UNDETERMINED, explain: ____

12. Diagnosis(es): ____ S/P Figure 8 ACL Repair

13. Major Contributing Cause: When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 11.
a) Is there a pre-existing condition contributing to the current medical disorder?
☐ a_1) NO ☐ a_2) YES ☐ a_3) UNDETERMINED as of this date
b) Do the objective relevant medical findings identified in Item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition?
☐ b_1) NO ☐ b_2) exacerbation ☐ b_3) aggravation ☐ b_4) UNDETERMINED as of this date
c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?
☐ c_1) NO ☐ c_2) YES
d) Given your responses to the Items above, is the injury/illness in question the major contributing cause for:
☐ d_1) NO ☐ d_2) YES the reported medical condition?
☐ d_3) NO ☐ d_4) YES the treatment recommended (management/treatment plan)?
☐ d_5) NO ☐ d_6) YES the functional limitations and restrictions determined?

SECTION II PATIENT CLASSIFICATION LEVEL

☑ 14. LEVEL I - Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment correlates to the specific findings.

☐ 15. LEVEL II - Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance, and Motor control. Treatment: physical reconditioning and functional restoration.

☐ 16. LEVEL III -Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating *both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.*

☐ 17. LEVEL UNDETERMINED AS OF THIS DATE.

SECTION III MANAGEMENT / TREATMENT PLAN

☐ 18. No clinical services indicated at this time. If checked, GO TO SECTION IV

☐ 19. No change in Items 20a – 20g since last report submitted. If checked, GO TO SECTION IV

20. The following proposed, subsequent clinical service(s) is/are deemed medically necessary.

*** THIS IS A PROVIDER'S WRITTEN REQUEST FOR INSURER AUTHORIZATION OF TREATMENT OR SERVICES. ***

☐ a) Consultation with or referral to a specialist. Identify principal physician: ____
Identify specialty & provide rationale: ____
☐ a_1) CONSULT ONLY ☐ a_2) REFERRAL & CO-MANAGE ☐ a_3) TRANSFER CARE

☐ b) Diagnostic Testing: (Specify) ____

☑ c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:
☐ c_1) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.
☐ c_2) Physical Reconditioning (Level II Patient Classification)
☐ c_3) Interdisciplinary Rehabilitation Program (Level III Patient Classification)
Specific instruction(s): ____ Home Exercises

☐ d) Pharmaceutical(s) (specify): ____

☐ e) DME or Medical Supplies: ____

☐ f) Surgical Intervention - specify procedure(s): ____
☐ f_1) In-Office: ____
☐ f_2) Surgical Facility: ____
☐ f_3) Injectable(s) (e.g. pain management): ____

☐ g) Attendant Care: ____

LAST FOLLOW UP, DR. LOEB, 11-12-2020 PG 2

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 2

Patient Name: ROBERT COLLINS	D/A: 05 / 06 / 2020	Visit/Review Date: 11 / 12 / 2020

SECTION IV FUNCTIONAL LIMITATIONS AND RESTRICTIONS

Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status related to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.

☑ 21. No functional limitations identified or restrictions prescribed as of the following date: __/__/__.

☐ 22. The injured workers' functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of the following date: __/__/__. *Use additional sheet if needed.*

☐ 23. The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient. Identify joint and/or body part ____. Use additional sheet if needed.

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
☐ Bend			
☐ Carry			
☐ Climb			
☐ Grasp			
☐ Kneel			
☐ Lift-floor > waist			
☐ Lift-waist>overhead			
☐ Pull			
☐ Push			
☐ Reach – overhead		Regular Duty	
☐ Sit			
☐ Squat		No Restrictions	
☐ Stand			
☐ Twist			
☐ Walk			
☐			
☐ Other			

COMMENTS:

Other choices; Skin Contact/ Exposure; Sensory; Hand Dexterity; Cognitive; Crawl; Vision; Drive/Operate Heavy Equipment; Environmental Conditions: heat, cold, working at heights, vibration; Auditory; Specific Job Task(s); etc.

NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date.

Specify those functional limitations and restrictions, in Item 23, which are permanent if MMI / PIR have been assigned in Item 24.

SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING

24. ✓ Patient has achieved maximum medical improvement?

☑ a) YES, Date 11/12/20 ☐ b) NO ☐ c) Anticipated MMI date: __/__/__

☐ d) Anticipated MMI date cannot be determined at this time. Future Medical Care Anticipated: ☐ e) YES ☑ f) No

☐ Comments: ____

25. 04 % Permanent Impairment Rating (body as a whole) Body part/system R Shoulder

26. Guide used for calculation of Permanent Impairment Rating (based on date of accident - see instructions):

☑ a) 1996 FL Uniform PIR Schedule ☐ b) Other, specify: ____

27. Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?

☐ a) YES ☑ b) NO ☐ c) Undetermined at this time.

SECTION VI FOLLOW-UP

28. Next Scheduled Appointment Date & Time: __/__/__ __:__ .m. (PRN)

SECTION VII ATTESTATION STATEMENT

"As the Physician, I hereby attest that all responses herein have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

"I certify to any MMI / PIR information provided in this form."

Physician Group: North Florida Sports Medicine

Date: 11 / 12 / 2020

Physician Signature: [signature]

Physician DOH License #: 59656

Physician Name: Peter E. Loeb,M.D. (print name)

Physician Specialty: Orthopaedic

If any direct billable services for this visit were rendered by a provider other than a physician, please complete sections below:

"I hereby attest that all responses herein relating to services I rendered have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

Provider Signature: ____

Provider DOH License #: PA9101256

Provider Name: Mark L. Marcewicz PA-C. (print name)

Date: 11 / 12 / 2020

Form DFS-F5-DWC-25 (revised 1/31/2008)

Armed – 8894 Deported – 0856

6-15-2020
MRI REPORT PG 1

Mon Jun 15 14:54:52 GMT 2020 -- Final Report

Patient Name : COLLINS^ROBERT^^^^
Patient ID [redacted]
Patient DOB : 19-Nov-1958
Accession Number : [redacted]

MRI RIGHT SHOULDER:

HISTORY: Right shoulder pain. Work-related injury on May 6, 2020.

TECHNIQUE: Routine sequences were performed on a high-field 3.0 Tesla Siemens MRI unit.

FINDINGS: There is a large full-thickness avulsion tear of the rotator cuff involving the entire supraspinatus tendon as well as the anterior portions of the infraspinatus tendon with retraction of the torn cuff underneath the acromion. The tear measures about 4 cm in width and the degree of cuff retraction is measured at a minimum of 2 cm but up to a maximum of 3.5 cm. A background of diffuse tendinitis is present. There is mild to moderate atrophy of both the supraspinatus and infraspinatus muscle bellies and there is also mild edema within portions of both muscle bellies. Fluid accumulation is seen in the subacromial / subdeltoid bursa as well as the subcoracoid bursa. There is also generalized deep soft tissue edema throughout the shoulder girdle. The subscapularis tendon contains a longitudinal interstitial partial-thickness tear that is nicely demonstrated on the axial and sagittal fat suppressed images. It measures 2.5 cm proximal to distal and about 3 x 3 mm in cross-section. It involves about 10-20% of tendon thickness and is superimposed upon a background of mild tendinitis. There is no subscapularis avulsion or retraction, however. The subscapularis muscle is only minimally distally atrophic.

There is severe acromioclavicular arthritis with mild joint space widening accompanied by a small joint effusion. There is mild subacromial spurring with a type II acromion associated with thickening of the coracoacromial ligament. These findings are producing impingement upon the rotator cuff.

The biceps tendon is intact with normal position in the bicipital groove. There is mild fraying of the tendon with mild tendinitis and tenosynovitis. No tear.

Glenohumeral alignment is normal. Mild joint space narrowing with low-grade chondromalacia and labral fraying. Moderate volume effusion with mild synovitis. No loose body. Capsule is thickened, fibrotic, and mildly edematous. There is also partial tearing of the anterior / inferior fibers of the joint capsule distally near the humeral attachments.

No fracture or bone contusion.

IMPRESSION:
1. Large full-thickness rotator cuff avulsion type tear with proximal cuff retraction, mild to moderate muscle atrophy, and mild muscle edema. This combination of findings is compatible with a subacute age of injury, which correlates well the given date of injury of about five weeks ago.
2. Subacromial / subdeltoid bursitis and subcoracoid bursitis, also presumably subacute in nature.
3. Chronic acromioclavicular arthritis with joint effusion and slight joint space widening.
4. Mild thinning and fraying of the biceps tendon with mild tendinitis, age

6-15-2020
MRI REPORT PG 2

indeterminate.
5. Low-grade glenohumeral chondromalacia with moderate volume joint effusion and mild synovitis.
6. Chronic-appearing partial-thickness anteroinferior capsular tear, at humeral attachments. This injury is felt to be chronic as the injured capsule shows thickening and fibrosis without accompanying soft tissue edema.

Erik Stromeyer, MD

Diplomate of the American Board of Radiology

Fellowship trained, Musculoskeletal MRI

ES/mo

INITIAL VISIT 5-5-2020 PG 1

Jet Medical Center
FIRST CLASS HEALTHCARE, FAST!

Work Status Worksheet

Name : Robert Collins
DOB : 11/19/1958
Date of Injury : 05/06/2020
Injury Number : 1

Employer State of Florida - All Depts
Contact :
Phone :
Fax :

Diagnosis

1. Abrasion of right elbow, initial encounter (S50.311A).
2. Unspecified sprain of right shoulder joint, initial encounter (S43.401A).
3. Strain of other flexor muscle, fascia and tendon at forearm level, right arm, initial encounter (S56.211A).
4. Unspecified sprain of right little finger, initial encounter (S63.616A).

Visit Date: 05/06/2020 Visit Type: Work Comp New
Time In: 4:00 PM Time Out: 5:13 PM Next Appointment: 05/08/2020 at 8:45 AM

Work Related: Yes ☑ No ☐ Not Determined ☐ Restricted Duty: Yes ☑ No ☐

Restrictions:

Restrictions: No lifting, pushing, pulling greater than 20 lbs. No reaching above right shoulder

☐ Discharged from care (no scheduled return visit - may follow-up as needed)
☐ Off work: ☐ until next visit
☐ Regular / Full Duty Work - No restrictions
☐ MMI with _____ % PIR as per the 1996 FUPIR Date/Time _____
☐ Follow-up with personal physician for care

TK PA-C
Medical Provider Signature

Tabitha Kicklighter, PA-C
Medical Provider

05/06/2020
Date

6-23-2020 PG 9

Jet Medical Center
FIRST CLASS HEALTHCARE, FAST!

Work Status Worksheet

Name : Robert Collins
DOB : 11/19/1958

Date of Injury : 05/06/2020
Injury Number : 1

Employer State of Florida - All Depts
Contact :
Phone :
Fax :

Diagnosis

1. Unspecified sprain of right shoulder joint, subsequent encounter (S43.401D).

Visit Date: 06/23/2020 Visit Type: Work Comp Recheck
Time In: 8:28 AM Time Out: 8:46 AM Next Appointment: 07/02/2020 at 8:30 AM

Work Related: Yes ☑ No ☐ Not Determined ☐ Restricted Duty: Yes ☑ No ☐

Restrictions:

Restrictions: No reaching above right shoulder

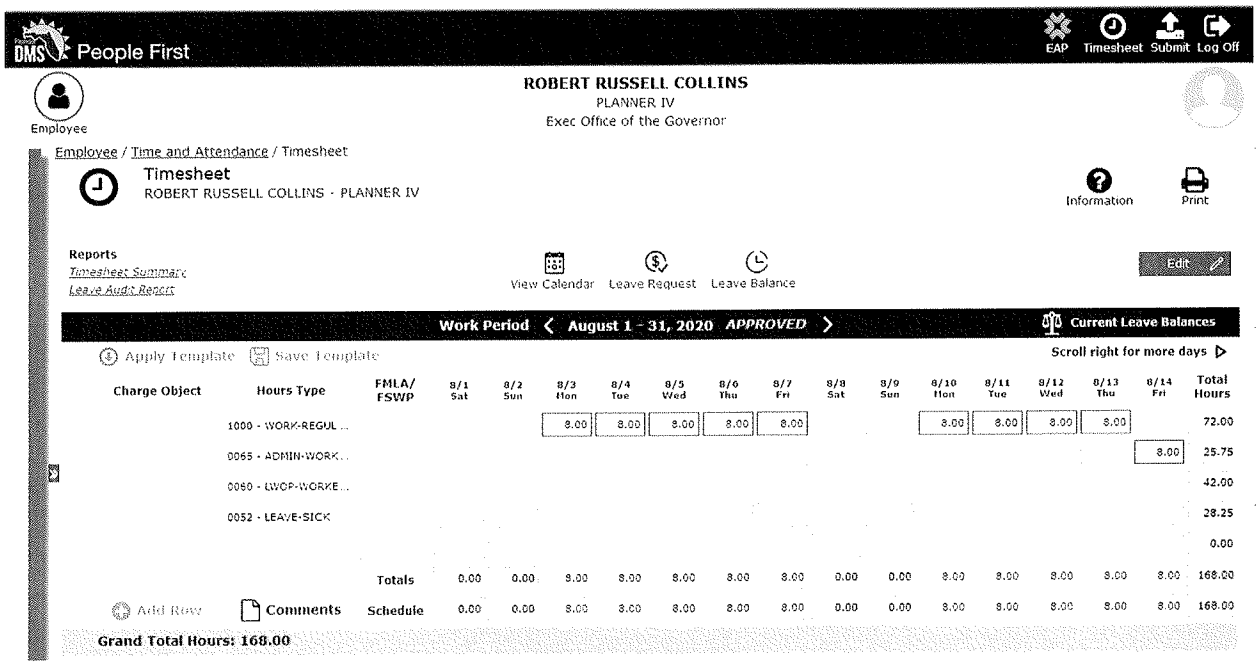
☐ Discharged from care (no scheduled return visit - may follow-up as needed)
☐ Off work: ☐ until next visit
☐ Regular / Full Duty Work - No restrictions
☐ MMI with _____ % PIR as per the 1996 FUPIR Date/Time _____
☐ Follow-up with personal physician for care

TK PA-C
Medical Provider Signature

Tabitha Kicklighter, PA-C
Medical Provider

06/23/2020
Date

AUGUST, 2020 TIMESHEETS



People First

EAP Timesheet Submit Log Off

Employee

ROBERT RUSSELL COLLINS
PLANNER IV
Exec Office of the Governor

Employee / Time and Attendance / Timesheet

Timesheet
ROBERT RUSSELL COLLINS - PLANNER IV

Information Print

Reports
Timesheet Summary
Leave Audit Report

View Calendar Leave Request Leave Balance

Edit

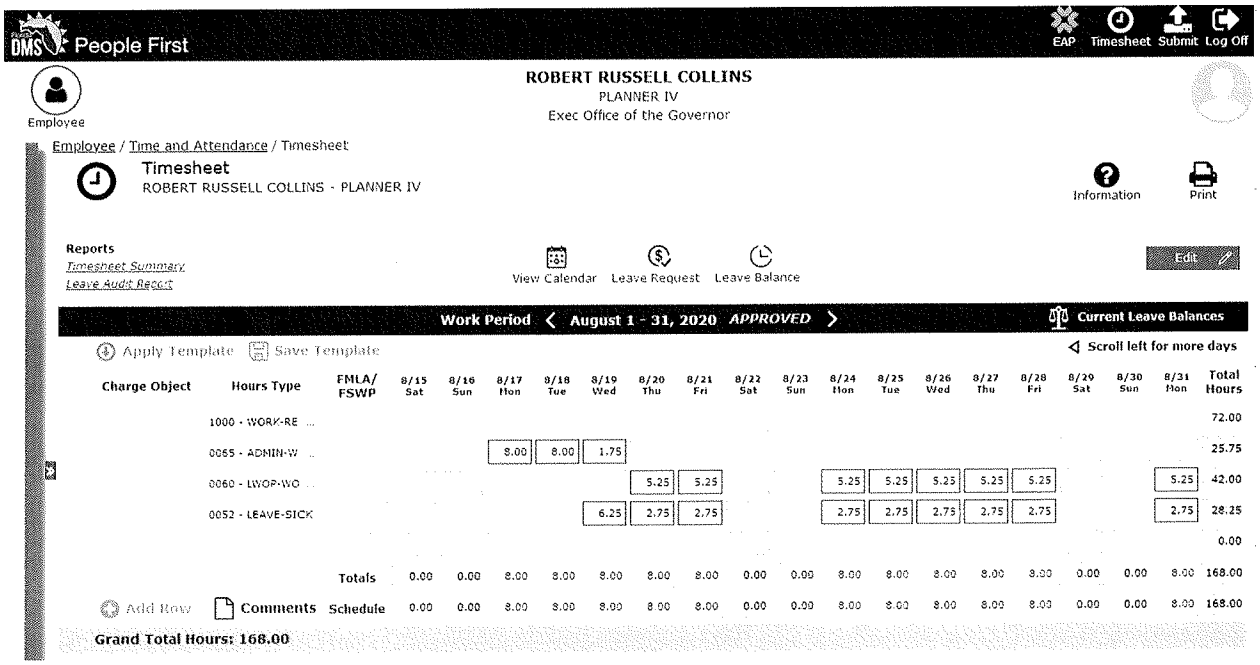
Work Period August 1 - 31, 2020 *APPROVED* **Current Leave Balances**

Apply Template Save Template

Scroll right for more days

Charge Object	Hours Type	FMLA/ FSWP	8/1 Sat	8/2 Sun	8/3 Mon	8/4 Tue	8/5 Wed	8/6 Thu	8/7 Fri	8/8 Sat	8/9 Sun	8/10 Mon	8/11 Tue	8/12 Wed	8/13 Thu	8/14 Fri	Total Hours
	1000 - WORK-REGUL ...				8.00	8.00	8.00	8.00	8.00			8.00	8.00	8.00	8.00		72.00
	0065 - ADMIN-WORK...															8.00	25.75
	0060 - LWOP-WORKE...																42.00
	0052 - LEAVE-SICK																28.25
																	0.00
		Totals	0.00	0.00	8.00	8.00	8.00	8.00	8.00	0.00	0.00	8.00	8.00	8.00	8.00	8.00	168.00
Add Row	Comments	Schedule	0.00	0.00	8.00	8.00	8.00	8.00	8.00	0.00	0.00	8.00	8.00	8.00	8.00	8.00	168.00

Grand Total Hours: 168.00



People First

EAP Timesheet Submit Log Off

Employee

ROBERT RUSSELL COLLINS
PLANNER IV
Exec Office of the Governor

Employee / Time and Attendance / Timesheet

Timesheet
ROBERT RUSSELL COLLINS - PLANNER IV

Information Print

Reports
Timesheet Summary
Leave Audit Report

View Calendar Leave Request Leave Balance

Edit

Work Period August 1 - 31, 2020 *APPROVED* **Current Leave Balances**

Apply Template Save Template

Scroll left for more days

Charge Object	Hours Type	FMLA/ FSWP	8/15 Sat	8/16 Sun	8/17 Mon	8/18 Tue	8/19 Wed	8/20 Thu	8/21 Fri	8/22 Sat	8/23 Sun	8/24 Mon	8/25 Tue	8/26 Wed	8/27 Thu	8/28 Fri	8/29 Sat	8/30 Sun	8/31 Mon	Total Hours
	1000 - WORK-RE ...																			72.00
	0065 - ADMIN-W ...				8.00	8.00	1.75													25.75
	0060 - LWOP-WO ...							5.25	5.25			5.25	5.25	5.25	5.25	5.25			5.25	42.00
	0052 - LEAVE-SICK						6.25	2.75	2.75			2.75	2.75	2.75	2.75	2.75			2.75	28.25
																				0.00
		Totals	0.00	0.00	8.00	8.00	8.00	8.00	8.00	0.00	0.00	8.00	8.00	8.00	8.00	8.00	0.00	0.00	8.00	168.00
Add Row	Comments	Schedule	0.00	0.00	8.00	8.00	8.00	8.00	8.00	0.00	0.00	8.00	8.00	8.00	8.00	8.00	0.00	0.00	8.00	168.00

Grand Total Hours: 168.00

SEPTEMBER, 2020 TIMESHEETS

People First

EAP Timesheet Submit Log Off

Employee

ROBERT RUSSELL COLLINS
PLANNER IV
Exec Office of the Governor

Employee / Time and Attendance / Timesheet

Timesheet
ROBERT RUSSELL COLLINS - PLANNER IV

Information Print

Reports
Timesheet Summary
Leave Audit Report

View Calendar Leave Request Leave Balance

Edit

Work Period < **September 1 - 30, 2020** ***APPROVED*** > **Current Leave Balances**

Apply Template Save Template

Scroll right for more days

Charge Object	Hours Type	FMLA/ FSWP	9/1 Tue	9/2 Wed	9/3 Thu	9/4 Fri	9/5 Sat	9/6 Sun	9/7 Mon	9/8 Tue	9/9 Wed	9/10 Thu	9/11 Fri	9/12 Sat	9/13 Sun	9/14 Mon	Total Hours
	1005 - HOLIDAY-STA ...								8.00								8.00
	1000 - WORK-REGUL ...															5.25	71.25
	0065 - ADMIN-WORK...																6.00
	0060 - LWOP-WORKE...		5.25	5.25	5.25	5.25				5.25	5.25	5.25	5.25				57.75
	0052 - LEAVE-SICK		2.75	2.75	2.75	2.75				2.75	2.75	2.75	2.75			2.75	33.00
		Totals	8.00	8.00	8.00	8.00	0.00	0.00	8.00	8.00	8.00	8.00	8.00	0.00	0.00	8.00	176.00
Add Row	Comments	Schedule	8.00	8.00	8.00	8.00	0.00	0.00	8.00	8.00	8.00	8.00	8.00	0.00	0.00	8.00	176.00

Grand Total Hours: 176.00

People First

EAP Timesheet Submit Log Off

Employee

ROBERT RUSSELL COLLINS
PLANNER IV
Exec Office of the Governor

Employee / Time and Attendance / Timesheet

Timesheet
ROBERT RUSSELL COLLINS - PLANNER IV

Information Print

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Timesheet Summary
Leave Audit Report

View Calendar Leave Request Leave Balance

Edit

Work Period < **September 1 - 30, 2020** ***APPROVED*** > **Current Leave Balances**

Apply Template Save Template

Scroll left for more days

Charge Object	Hours Type	FMLA/ FSWP	9/15 Tue	9/16 Wed	9/17 Thu	9/18 Fri	9/19 Sat	9/20 Sun	9/21 Mon	9/22 Tue	9/23 Wed	9/24 Thu	9/25 Fri	9/26 Sat	9/27 Sun	9/28 Mon	9/29 Tue	9/30 Wed	Total Hours
	1005 - HOLIDAY-S ...																		8.00
	1000 - WORK-REG ...					7.00			7.00	8.00	7.00	8.00	7.00			7.00	8.00	7.00	71.25
	0065 - ADMIN-WO ...					1.00			1.00		1.00		1.00			1.00		1.00	6.00
	0060 - LWOP-WOR ...		5.25	5.25	5.25														57.75
	0052 - LEAVE-SICK		2.75	2.75	2.75														33.00
		Totals	8.00	8.00	8.00	8.00	0.00	0.00	8.00	8.00	8.00	8.00	8.00	0.00	0.00	8.00	8.00	8.00	176.00
Add Row	Comments	Schedule	8.00	8.00	8.00	8.00	0.00	0.00	8.00	8.00	8.00	8.00	8.00	0.00	0.00	8.00	8.00	8.00	176.00

Grand Total Hours: 176.00

Financial Disclosure Management System
THE FLORIDA COMMISSION ON ETHICS

Filer - Fines and Appeals - PID 283002 - Robert Russell Collins

Filer Information
Org Membership
Forms
Communications
Fines and Appeals >
View All

Filer Flags

2000 2001 2002 2003 2004
2005 2006 2007 2008 2009
2010 2011 2012 2013 2014
2015 2016 2017 2018 2019($)
2020

<<2020 Form Year

Status
Filing: ACTIVE
Fine: No Fine
Flags
Public Address
Filing Extensions
Indefinite: None
Temporary: None
Eligible for Fines

Update Flags

The filer has fines for: 2020 (Appeal)

2020 Fines and Appeals

Form Year 2019 Filed Forms						
Received Date	Form Type	Form Signed	Filed by Email	Filing Location	Updated	Comments
09/21/20	Form 1	Yes	Yes	COE	PRINEE on 09/21/2020	

2020 Fine Information			Update Fine Information / Assign Agency Contact				
Fine Balance	Fine Status	Fine Date	Original Assessment	Fine Amount	Last Payment Date	Payment Plan Start Date	Payment Plan Amount
$500.00	Appeal	3/16/2021	$500.00	$500.00			
Fine Address 1806 Gibbs Dr Tallahassee FL 32303 Org/Suborg Division of Emergency Management-Employees							

2020 Fine Payment History					
Date Posted	Description	Amount	Method	Payment ID	Comments
3/16/2021	Fine Levied	+ $500.00			Fined $500.00
Current Balance: $500.00					

2020 Fine Year Event

Invalidate Transaction

Add a New Filer

Jump To A Filer

PID: Go

Quick Filer Search

First Name:

Last Name:

Search

Chronology

Date	Type	Description	Reference
02/26/2020	Filer Communication: Email	From: Prine.Emily Sent: Wednesday, February 26, 2020 10:06 AM To: Dykes, Dana Subject: [EXTERNAL] Disclosure List Importance: High We are working on your disclosure list. We have multiple records under the name Robert Collins, do you have middle name or initial. Has he served in other capacities requiring disclosure? We try to avoid duplications. His middle name is Russell.	Emily Prine
05/19/2020	Letter Sent	Form 1 Official List - Form 1 Official Filers List	Print Queue: 5/19/2020 7:55 AM Printing Confirmed: 5/19/2020 7:55 AM

Letter Sent To:
Robert Russell Collins
2555 Shumard Oak Blvd
Tallahassee, FL 32399 -7018

07/31/2020	Letter Sent	Certified Letter Sent	Print Queue: 7/31/2020 Printing Confirmed: 7/31/2020

Letter Sent To:
Robert Russell Collins
2555 Shumard Oak Blvd
Tallahassee, FL 32399 -7018

08/20/2020	Postcard Sent	Courtesy Postcard Reminder	Print Queue: 8/20/2020

Printing Confirmed: 8/20/2020

Letter Sent To:
Robert Russell Collins
2555 Shumard Oak Blvd
Tallahassee, FL 32399 -7018

09/8/2020	Letter Sent	Courtesy Notice of Fines Accruing	Print Queue: 9/8/2020 Printing Confirmed: 9/8/2020

Letter Sent To:
Robert Russell Collins
2555 Shumard Oak Blvd
Tallahassee, FL 32399 -7018

09/21/2020	Form Received	Form 1 Received, Signed	Form 1 Received by Emily Prine at COE

Form Received By: Emily Prine
Filing Location: COE
Record Created By: Emily Prine on 09/21/2020

09/21/2020	Filer Communication: Email	From: Collins, Robert Sent: Monday, September 21, 2020 4:27 PM To: COE-Form1 Cc: Collins, Robert Subject: Statement of Financial Interests 2019 Bob Collins Catastrophic Planner Florida Division of Emergency Management Bureau of Preparedness | All-Hazards Preparedness Unit 2555 Shumard Oak Blvd. Tallahassee, FL 32399-1718 Direct Line: (850) 815-4336 Robert.Collins@em.myflorida.com	Emily Prine

	09/21/2020	Filer Communication: Email	From: COE-Form1 Sent: Monday, September 21, 2020 4:40 PM To: 'Collins, Robert' Subject: RE: Statement of Financial Interests 2019 Thank you. Form was recorded. In January, you will receive information concerning your fine assessment and the option to appeal. The mailing will go to 2555 Shumard Oak Blvd.	Emily Prine
	03/16/2021	Fine Levied	Fined $500.00	Journal: 3/16/2021 9:23 AM
	03/16/2021	Notice of Assessed Fine	Initial Fine Notice	Journal: 3/16/2021 10:02 AM
	03/16/2021	Letter Sent	Notice of Assessed Fine - Filer 1st Fine Letter	Print Queue: 3/16/2021 Printing Confirmed: 3/16/2021

Letter Sent To:
Robert Russell Collins
2555 Shumard Oak Blvd
Tallahassee, FL 32399 -7018

	04/21/2021	Fine Appeal	FD 20-032	Journal: 4/21/2021 5:40 PM
	04/23/2021	Letter Sent	Fine Appeal	Print Queue: 4/23/2021 Printing Confirmed: 4/23/2021

Letter Sent To:
Robert Russell Collins
1806 Gibbs Dr

Tallahassee, FL 32303

2020 Fine Appeal – FD 20-032	Update Appeal | Withdraw Appeal Assign Attorney | Request More Info Record Appeal Outcome
Appeal Status: Active **Appeal Receipt Date:** 04/15/2021 **Timely Filed:** Yes **Print Appeal Letter:** Yes **Hearing Requested:** No **Appeal Reason:** Illness or Injury **Appeal Notes:** **Appeal Number:** FD 20-032 **Appeal Analyst Assigned:** **Final Order Number:** **Final Order Date:**	No Hearing Requested