

**District of Columbia Government** Office of Workers' Compensation 4058 Minnesota Avenue, N.E. Washington, DC 20019

(202) 671-1000

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Employee Name and Address:** 

Date of This Report
Employee Social Security No.
Employer Identification No.
Insurer No.

Insurer Name and Address:

## EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE Employer Name and Address:

IMPORTANT: Every employer shall file this report as sits employees, but no later than ten (10) days thereafte				
Date and time of Injury:	am/nm2	Day of the week?		
Normal starting time:am/pm? If employee				
At what wage? If fatal,				
Date/time disability began?				
Was the injured given Form No. 7 DCWC? Yes No				
When did you or the foreman first learn of the injury?				
Male Female DOB: Employee's Telep				
Occupation when injured?				
(Department or branch regularly employed):	was this his/her h	egulai occupation:		
Was the injured hired in DC? How los				
Piece or time worker?	Housing wage?	Hours worked/day2		
Daily wages: Days worked per weel	Hourry wage?	Hours worked/day? _	/ oorningo:	
If board and lodging were furnished or gratuities reported				
		stilllated value per day, week,	or monus	
Employer's principal business function in DC:		- Dollov No :		
	Insurance Policy No.: occurred:			
On employer's premises?			tining to the standard of the	
Describe fully the events which resulted in injury or diseas body affected:	• •	•	injury including parts of the	
body anoticu.				
Name of Witnesses:				
Nature and location of injury (Describe fully):				
Attending Physician and Address (If Hospital Involved – Ir				
Attending 1 hysician and Address (ii Hospital involved – ii	idicate)			
		Name (Please Print or Typ	e)	
Name of Person Completing Form		Signature		
	<del></del>	Official Position		