



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.*

Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

IMPORTANT: Every employer shall file this report as soon as possible after knowledge of an occupational injury or disease to one of its employees, but no later than ten (10) days thereafter. Failure to file this form shall be subject to civil penalty not to exceed \$1,000.

Date and time of Injury: _____ am/pm? Day of the week? _____

Normal starting time: _____ am/pm? If employee back to work, give date and time: _____ am/pm?

At what wage? _____ If fatal, give date of death _____ (file supplement report)

Date/time disability began? _____ am/pm? Was the injured paid in full for this day? _____

Was the injured given Form No. 7 DCWC? ☐ Yes ☐ No Foreman/Supervisor _____

When did you or the foreman first learn of the injury? _____

☐ Male ☐ Female DOB: _____ Employee's Telephone No.: _____

Occupation when injured? _____ Was this his/her regular occupation? _____

(Department or branch regularly employed): _____

Was the injured hired in DC? _____ How long employed by you? _____

Piece or time worker? _____ Hourly wage? _____ Hours worked/day? _____

Daily wages: _____ Days worked per week: _____ Average weekly earnings: _____

If board and lodging were furnished or gratuities reported in addition to wages, give estimated value per day, week, or month: _____

Employer's principal business function in DC: _____

Employer's Telephone No.: _____ Insurance Policy No.: _____

Location of plant or place where accident occurred: _____

On employer's premises? _____

Describe fully the events which resulted in injury or disease, what the employee was doing when injured and type of injury including parts of the body affected: _____

Name of Witnesses: _____

Nature and location of injury (Describe fully): _____

Attending Physician and Address (If Hospital Involved – Indicate): _____

Name of Person Completing Form

Name (Please Print or Type)

Signature

Official Position