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): ______________________

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

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____
Name (Please Print or Type)

____
Name of Person Completing Form

____
Signature

____
Official Position