**District of Columbia Government**
**Office of Worker¸s Compensation**
**P.O. Box 56098**
**Washington, DC 20011**
(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 his/her employees, but no later than ten 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 of disability began? ________________ am/pm? Was the injured paid in full for this day? ________________

Was the injured given Form No. 7 DCWC? ________________ Foreman________________

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 (Please Print or Type)

______________________________
Name of Person Completing Form

______________________________
Signature

______________________________
Official Position



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