

**DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKERS' COMPENSATION
P.O. BOX 56098
WASHINGTON, D.C. 20011**

(202)576-6265

Date of This Report

Employee Social Security No.

Employee 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 employees, but no later than ten days thereafter. Failure to file this form shall be subject to a civil penalty not to exceed \$1,000.

Date and Time of Injury _____ am/pm? Day of 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 disability began? _____ am/pm? Was injured paid in full for this day? _____

Was injured given Form No. 7 DCWC? _____ Foreman _____

When did you or foreman first know of injury? _____

Male _____ Female _____ Age _____ Employee's Telephone No. _____

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

(Department or branch regularly employed) _____

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

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

Daily wages _____ Days worked per week _____ Avg. 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 body affected: _____

Names 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

ORIGINAL - OWC OFFICE