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:
KhodalDham full name ABC street		sdfdsfd ABC street

IMPORTANT: Every employer shall file this report as soon as possible after knowledge of an occupational injury or disease to one of his/her's 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 01/01/1970 05:30 AM am/pm? Day of the week? dsf
Normal starting time 02:30 PM am/pm? If employee back to work, give date 12/16/2021 am/pm? At what wage? dsf If fatal, give date of death 12/23/2021 (file supplement report)
Date of disability began? 12/22/2021 am/pm? Was the injured paid in full for this day? dsf
Was the injured given Form No. 7 DCWC? dsf Foreman df
When did you or the foreman first learn of the injury? sdfd
Male ____ Female ☑ DOB ____ Employee's Telephone No. 1234567890
Occupation when injured? Consequatur aut und Was this his/her regular occupation? fdg
(Department or branch regularly employed) dsfdsf
Was the injured hired in DC? dfd How long employed by you? fdsf
Piece or time worker? sdfsd Hourly wage? fdsf Hours worked/day dsf
Daily wages sdf Days worked per week sdfsd Average weekly earnings sdf If board and lodging were furnished or gratuities reported in addition to wages, give estimated value per day, week or month: sdfsdf
Employer's principal business function in DC
Employer's Telephone No. 1234567890 Insurance Policy No. dsf
Location of plant or place where accident occurred: dsf
On employer's premises? FDs
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): dsf

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

dsf

Name (Please Print or Type)

Name of Person Completing Form

Signature

Official Position