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:
Megan Amrhine 341 Elm St NW Washington, DC 20001		Liberty Mutual Insurance 341 Elm St NW Washington, DC 20001

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 12/27/2021 09:00 AM am/pm? Day of the week? 5
Normal starting time 07:45 AM am/pm? If employee back to work, give date 01/10/2022 am/pm? At what wage? n/a 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. 540-322-6647
Occupation when injured? Speech Therapist Was this his/her regular occupation? Speech Therapist
(Department or branch regularly employed) _____
Was the injured hired in DC? _____ How long employed by you? 6 months
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. 540-322-6647 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: Therapist treated resident on 12.27.21 who was later transfer to hospital and diagnosed

Name of Witnesses _____
Nature and location of injury (Describe fully): Therapist had direct contact with resident who was later day transfer to

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

Therapist was self quarantine and took PCR tests.

Name (Please Print or Type)

Name of Person Completing Form

Signature

Official Position