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:
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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 12/23/2021 12:41 PM am/pm? Day of the week? 4
Normal starting time 11:45 AM am/pm? If employee back to work, give date 12/15/2021 am/pm? At what wage? 150 If fatal, give date of death 12/15/2021 (file supplement report)
Date of disability began? 12/18/2021 am/pm? Was the injured paid in full for this day? Test unjured
Was the injured given Form No. 7 DCWC? NO Foreman tetst fireman
When did you or the foreman first learn of the injury? At thi symh fg56
Male [✔] Female [ ] DOB 06/16/2020 Employee's Telephone No. 987-654-7895
Occupation when injured? Buyuyuy Was this his/her regular occupation? not sure about tghis
(Department or branch regularly employed) test depart en
Was the injured hired in DC? Yes How long employed by you? it by 78 tumes
Piece or time worker? Piece Hourly wage? 4 Hours worked/day 7
Daily wages 28 Days worked per week 4 Average weekly earnings 108 If board and lodging were furnished or gratuities reported in addition to wages, give estimated value per day, week or month: 100000
Employer's principal business function in DC gfh
Employer's Telephone No. 987-654-7895 Insurance Policy No. 98745632155 cS
Location of plant or place where accident occurred: At Thi road, Nr test streeeeeeeeeet
On employer's premises? jhjhhkhk
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: yhrt

Name of Witnesses yrty
Nature and location of injury (Describe fully): body of Eye

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

Yesiiuiui

Name (Please Print or Type)

Name of Person Completing Form

Signature

Official Position