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:
Nick Jonas G - 308, Test Street, San Francisco		Nick C Jonas G - 308, Test Street, San Francisco

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 12/01/2021 09:30 AM am/pm? Day of the week? 5
Normal starting time 10:45 PM am/pm? If employee back to work, give date 12/02/2021 am/pm? At what wage? 45 If fatal, give date of death 12/03/2021 (file supplement report)
Date of disability began? 12/04/2021 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? Not sure about that
Male ☑ Female _____ DOB 12/05/2021 Employee's Telephone No. 987-456-3215
Occupation when injured? School Was this his/her regular occupation? Signing
(Department or branch regularly employed) Song
Was the injured hired in DC? Yes How long employed by you? 78
Piece or time worker? Piece Hourly wage? 4 Hours worked/day 7
Daily wages 28 Days worked per week 5 Average weekly earnings 98 If board and lodging were furnished or gratuities reported in addition to wages, give estimated value per day, week or month: 35
Employer's principal business function in DC Test Principal
Employer's Telephone No. 987-456-3215 Insurance Policy No. 9632587414
Location of plant or place where accident occurred: Street of California
On employer's premises? Yes
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: Test Description

Name of Witnesses Priyanka Chopra Jonas (96547863215)
Nature and location of injury (Describe fully): test Nature and Injury

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

Dr. Suresh Sharma, City Hospital, Nr Test Street, San Francisco.

Name (Please Print or Type)

Name of Person Completing Form

Signature

Official Position