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 12/15/2021 08:05 AM am/pm? Day of the week? 5g
Normal starting time 04:45 P am/pm? If employee back to work, give date and time 12/16/2021 12:00 AM am/pm? At what wage? 45 If fatal, give date of death 12/17/2021 (file supplement report) Date of disability began? 12/17/2021 am/pm? Was the injured paid in full for this day? Test unjured: Was the injured given Form No. 7 DCWC? NO1 Foreman tetst fireman1 When did you or the foreman first learn of the injury? foreman Male [✔] Female [ ] DOB 02/02/2021 Employee's Telephone No. 9874563215
Occupation when injured? Buyuyuy Was this his/her regular occupation? Noyt sure
(Department or branch regularly employed) qwe
Was the injured hired in DC? Yes How long employed by you? 78
Piece or time worker? Piece Hourly wage? 78 Hours worked/day 45
Daily wages 28 Days worked per week 4 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: lodging
Employer's principal business function in DC function in DC
Employer's Telephone No. 9874563215 Insurance Policy No. Insurance
Location of plant or place where accident occurred: plant or place
On employer's premises? employer's
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 wit 1 . wiyter 2
Nature and location of injury (Describe fully): nikol

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

Dr. Suresh , Nikol, HAmedafgad

Name (Please Print or Type)

Name of Person Completing Form

Signature

Official Position