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:
Nevada Joyner		Dana Haynes

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 _____ am/pm? Day of the week? 10
Normal starting time 07:00 P am/pm? If employee back to work, give date and time 0000-00-00 am/pm? At what wage? Voluptatem amet If fatal, give date of death 12-Mar-1985 (file supplement report) Date of disability began? 12/15/2021 am/pm? Was the injured paid in full for this day? 26 Was the injured given Form No. 7 DCWC? Voluptatem nostru Foreman Vel aperiam consequa When did you or the foreman first learn of the injury? Et ullam et sunt su Male [✔] Female _____ DOB 12/29/20 Employee's Telephone No. +1 (975) 748-4967
Occupation when injured? Consequatur aut und Was this his/her regular occupation? Deserunt sed cum ita
(Department or branch regularly employed) Sed quibusdam placea
Was the injured hired in DC? Ea tempora How long employed by you? Tempora sit fugiat
Piece or time worker? Officia reprehenderi Hourly wage? Itaque atqu Hours worked/day 10
Daily wages Dolorum illo c Days worked per week 15 Average weekly earnings 1970 If board and lodging were furnished or gratuities reported in addition to wages, give estimated value per day, week or month: Sed eum iste e
Employer's principal business function in DC Laudantium providen
Employer's Telephone No. _____ Insurance Policy No. Dolore veniam sunt
Location of plant or place where accident occurred: Ad ut suscipit aut a On employer's premises? Proident aperiam cu
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: Duis alias et facili

Name of Witnesses _____
Nature and location of injury (Describe fully): Ipsam enim natus eli

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

Et consectetur aliqu

Name (Please Print or Type)

Name of Person Completing Form

Signature

Official Position