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:

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? _____
Normal starting time _____ am/pm? If employee back to work, give date _____ am/pm? At what wage? _____ 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. _____
Occupation when injured? _____ Was this his/her regular occupation? _____
(Department or branch regularly employed) _____
Was the injured hired in DC? _____ How long employed by you? _____
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. _____ 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: _____

Name of Witnesses _____
Nature and location of injury (Describe fully): _____

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

_____
Name (Please Print or Type)

_____
Name of Person Completing Form

_____
Signature

_____
Official Position