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:
Hetal twatr		test twatr

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 12/25/2021 05:50 PM am/pm? Day of the week?
Normal starting time 05:00 P am/pm? If employee back to work, give date and time 11/30/-0001 12:00 AM am/pm? At what wage? 50 If fatal, give date of death (file supplement report) Date of disability began? 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? 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