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 01/01/1970 05:30 AM am/pm? Day of the week? 5
Normal starting time 06:15 P am/pm? If employee back to work, give date and time 11/30/-0001 12:00 AM am/pm? At what wage? 15 If fatal, give date of death 12/30/2021 (file supplement report) Date of disability began? 12/28/2021 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? at this time Male _____ Female ✔ DOB 11/30/20 Employee's Telephone No. 987-456-3215
Occupation when injured? Buyuyuy Was this his/her regular occupation? Noyt sure
(Department or branch regularly employed) Test depart
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 45 Days worked per week 79 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: board and lodg
Employer's principal business function in DC principal business functio
Employer's Telephone No. _____ Insurance Policy No. 9874563
Location of plant or place where accident occurred: Florida On employer's premises? NOI""""
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: 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): Test nature body

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

Yes

Name (Please Print or Type)

Name of Person Completing Form

Signature

Official Position