District of Columbia Government
Office of Worker's Compensation
P.O. Box 56098
Washington, DC 20011
(202) 671-1000

Date of This Report ____________________

Employee Social Security No. ____________________

Employer Identification No. ____________________

Insurer No. ____________________

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.*

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 and time ______________________am/pm?
At what wage? ______________________ If fatal, give date of death ______________________(file supplement report)
Date of disability began? ______________________ am/pm? Was the injured pain 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 ______________________

DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKER'S COMPENSATION
P.O. BOX 56098
WASHINGTON, D.C. 20011

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Employee Social Security No.: ______________________

Employer Identification No.: ______________________

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EMPLOYEE'S
NOTICE OF ACCIDENTAL INJURY OR OCCUPATION DISEASE

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

NOTICE TO EMPLOYEE

YOU MUST FILE THIS REPORT WITHIN 30 DAYS AFTER YOU BECOME AWARE OF AN ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE AND ITS RELATIONSHIP TO YOUR JOB. PART 1 SHOULD BE MAILED TO THE D.C. GOVERNMENT, OFFICE OF WORKERS' COMPENSATION AT THE ABOVE ADDRESS. PART 2 SHOULD BE MAILED OR DELIVERED TO YOUR EMPLOYER, AND PART 3 RETAINED FOR YOUR RECORDS. IN ORDER TO PRESERVE YOUR RIGHTS UNDER THE LAW, YOU MUST FILE A CLAIM FORM NO. 7a DCWC, A COPY OF WHICH CAN BE OBTAINED FROM YOUR EMPLOYER OR THE OFFICE OF WORKERS' COMPENSATION.

Date and Time of Injury: ______________________ am/pm?

Place where injury occurred: ______________________

Description of Injury: ______________________

____

THIS IS TO NOTIFY YOU ______________________
(Employer)

THAT I ______________________ while in your employ, sustained an injury ☐ or contracted an occupational disease ☐ as described above, caused by:

____

Treating Physician's Name and Address: ______________________

____

FORM NO. 7 DCWC

____
(Employee's Signature)