DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKERS COMPENSATION
P.O. BOX 56098
WASHINGTON, D.C. 20011
(202) 576-6265

Date of This Report

Employee Social Security Number

Employer Identification Number

Insurer Number

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 employees, but no later than ten days thereafter. Failure to file this form shall be subject to a civil penalty not to exceed $1,000.

Date and Time of Injury _____ am/pm? Day of 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 disability began? _____ am/pm? Was injured paid in full for this day?

Was injured given Form No. 7 DCWC? _____ Foreman

When did you or foreman first know of injury?

Male _____ Female_____ Age _____ Employee's Telephone No.

Occupation when injured _____ Was this his/her regular occupation?
_(Department or Branch where regularly employed)

Was injured hired in DC? _____ How long employed by you?

Piece or time worker? _____ Hourly wage? _____ Hours worked/day

Daily wages _____ Days Worked per Week _____ Avg 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 body affected:

Names 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

FORM NO. 8 DCWC

9-2491