

THE DISTRICT OF COLUMBIA GOVERNMENT
 OFFICE OF WORKERS' COMPENSATION
 P.O. BOX 56098
 WASHINGTON, D.C. 20011
 (202) 671-1000

 Date of This Report

 Employee Social Security No.

 Employer Identification No.

 Insurer No.

**NOTICE OF CONTROVERSION
 MEMO OF DENIAL OF WORKERS' COMPENSATION BENEFITS**

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

Date of Accident _____ Date First Report Received _____

YOUR WORKERS' COMPENSATION BENEFITS ARE HEREBY DENIED BY EMPLOYER OR INSURER FOR REASON(S) INDICATED BELOW. IF YOU DISAGREE, YOU MAY APPLY FOR A HEARING BY COMPLETING FORM NO. 20 (ON THE REVERSE). THE HEARING WILL BE SCHEDULED WITHIN 20 WORKING DAYS AFTER RECEIPT OF THIS NOTICE. IN THE INTERIM, IF YOU WISH TO PARTICIPATE IN AN INFORMAL CONFERENCE, YOU MAY CALL 576-6265 OR WRITE THE DIRECTOR AT THE ADDRESS ABOVE. YOU MAY BE REPRESENTED AT SUCH PROCEEDINGS IF YOU SO DESIRE, AND YOU WILL BE ADVISED IN WRITING OF THE PLACE, DATE AND TIME. IF YOU HAVE NOT ALREADY FILED AN EMPLOYEE'S CLAIM APPLICATION, FORM NO. 7a DCWC, YOU MUST DO SO WITHIN ONE (1) YEAR OF THE DATE OF INJURY OR ONE (1) YEAR AFTER THE LAST PAYMENT OF COMPENSATION BENEFITS BY YOUR EMPLOYER.

REASONS

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|---|---|
| 1. <input type="checkbox"/> No Employer-Employee Relationship | 4. <input type="checkbox"/> Continuing Disability Contested |
| 2. <input type="checkbox"/> No Causal Relationship to Employment | 5. <input type="checkbox"/> No Jurisdiction Under D.C. Law |
| 3. <input type="checkbox"/> Improper Notice of Injury by Employee | 6. <input type="checkbox"/> Other |

Explanation: _____

Authorized Representative _____

INITIAL DENIAL

SUBSEQUENT DENIAL