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.

REPORT OF EXTENDED DISABILITY

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

This form shall be completed by the insurer and filed with the Office of Workers' Compensation on every case where total disability benefits are anticipated to continue, or have continued for three (3) months, as required by Section 8(a).

Check ( ) Male ☐ Female ☐ Single ☐ Married ☐ Age ☐

Education, Circle Highest: 1 2 3 4 5 6 7 8 9 10 11 12 (Primary) (Secondary) 1 2 3 4 (College) POST GRADUATE

INJURY DATE: _____ (Month/Day/Year) DISABILITY DATE: _____ (Month/Day/Year)

NATURE AND LOCATION OF INJURY: _____

Date employer was contacted as to claimant's return to employment: _____

Employer's response: Yes ☐ No ☐ _____ (Name of Person Contacted)

If yes, in what capacity: _____

_____ (Date) _____ (Insurer Representative's Signature)

ENCLOSE ANY UP-TO-DATE MEDICAL REPORTS

FORM NO. 13 DCWC
9-2495

ORIGINAL - OWC