

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.

MEMO OF PERMANENT PARTIAL DISABILITY AWARD

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

Date of Injury: _____

Date of Return to Work: _____

Place of Work: _____
Name
Address

Earnings after Return To Work: _____ per _____

Description of Permanent Partial Disability: _____

AWARD

**SUBJECT TO REVIEW AND
APPROVAL BY DIRECTOR**

IMPORTANT
Attach Medical Report

Weekly Rate: _____ (@ 66⅔ of) Average Weekly Wage: _____

Beginning Date: _____ No. of Weeks: _____

Date Signature

Telephone Number Title

THIS AWARD IS SUBJECT TO REVIEW AND ADJUSTMENT UPON PRESENTATION OF OTHER EVIDENCE

OFFICE APPROVAL