THE 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 No.: ____________

Employer Identification No.: ____________

Insurer No.: ____________

NOTICE OF FINAL PAYMENT OF COMPENSATION PAYMENTS

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

INSTRUCTIONS: This notice must be filed with the Office of Workers' Compensation, P.O. Box 56098, Washington, D.C. 20011, within 16 days after compensation has ended, subject to civil penalty.

Date of Injury: ____________ Date of Last Payment: ____________

Date employee returned to work: ____________ Date employee lost pay because of injury: ____________

Date physician stated employee able to return to work: ____________

Was compensation paid at the maximum rate? ☐ Yes ☐ No

Average weekly wage $____________ multiplied by ⅔ = Compensation rate $____________ or 80% of spendable income

State reason or reasons for ending of payments:

ENTER ALL DISABILITY PAYMENTS

TYPE OF DISABILITY a	FROM (mo-day-yr) b	TO (mo-day-yr) c	AMT. PAID PER WEEK d	NO. OF WEEKS PAID e	TOTAL f
Temporary total					
Temporary partial					
Permanent Partial (non-schedule)					
Permanent Partial (Schedule loss, facial or other disfigurement)	Percent	Part of body			
				TOTAL	**$**

ENTER OTHER PAYMENTS

a. Attorney fees	**c. Interest**	
b. Penalty for late payment	**TOTAL (Cols. a,b,c)** →	

Name of insurance carrier or self-insured employer

Signature of person authorized to sign for carrier | **TITLE**

EMPLOYEE PLEASE READ CAREFULLY — **If you have any permanent impairment of the body or other disability from the injury for which you have not received compensation, you should inform the Director at the above address of same, and request Form No. 7a DCWC in order to preserve your claim and rights under the law.**

FORM NO. 15 DCWC INSURER COPY