DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKER'S COMPENSATION
P.O. BOX 56098
WASHINGTON, D.C. 20011

(202) 671-1000

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.

Date of This Report ______________________

Employee Social Security No. ______________________

Employer Identification No. ______________________

Insurer No. ______________________

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 his/her regular occupation? ______________

(Department or branch 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: ______________

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____

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

ORIGINAL – OWC OFFICE