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 PAYMENT OF WORKERS' COMPENSATION

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

The employer is required to pay total disability compensation and to file with the Office, copy to employee, memorandum of payment in accordance with Section 16 (c), *as soon as possible after date of knowledge of injury, but by the fourteenth day thereafter*. Filing shall also be made upon making provisional payment, adjusting such payment, and upon making payment resulting from Office hearing. Failure to pay and to file memorandum promptly, in the absence of a legitimate denial of benefit, shall subject the employer to an added ten percent (10%) of payment.

Date of Injury: ______________

Description of Injury: ______________

	Disa./Recurrence	1st or Sup. Rep. R'cd.	1st Payment	2nd Payment
DATE				

Compensation at the rate of $______________ per week

☐ **2/3 of Gross Earnings** ☐ **80% of Spendable Earnings**

Beginning ______________ **Average weekly wage of $** ______________

Compensation payment voluntary ☐
Compensation payment results from Office hearing award ☐
Memo indicating provisional payment already filed ☐
Memo indicating adjustment in total disability ☐

SEE ATTACHED WAGE SCHEDULE, EXCEPT IF MAXIMUM COMPENSATION OR DISABILITY IS LESS THAN SEVEN (7) DAYS.

MISSING WAGE SCHEDULE ☐

When expected? ______________ **Provisional Payment of $______________, subject to later adjustment.**

____
Signature

____
Office Approval & Date

____
Telephone Number

FORM NO. 9 DCWC
9-2492

ORIGINAL - OWC