District of Columbia Government
Office of Workers' Compensation
4058 Minnesota Avenue, N.E.
Washington, D.C. 20019
(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 its employees, but no later than ten (10) days thereafter. Failure to file this form shall be subject to civil penalty not to exceed $1,000.

Date and time of Injury: _____ am/pm? Day of the 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/time disability began? _____ am/pm? Was the injured paid in full for this day? _____
Was the injured given Form No. 7 DCWC? ☐ Yes ☐ No Foreman/Supervisor _____
When did you or the foreman first learn of the injury? _____
☐ Male ☐ Female DOB: _____ Employee's Telephone No.: _____
Occupation when injured? _____ Was this his/her regular occupation? _____
(Department or branch regularly employed): _____
Was the injured hired in DC? _____ How long employed by you? _____
Piece or time worker? _____ Hourly wage? _____ Hours worked/day? _____
Daily wages: _____ Days worked per week: _____ Average 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 incident 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 the body affected: _____

Name 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