

(202) 671-1000

Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

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.

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 \$1000.

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 this his/her regular occupation? _____ (Dept. or Branch where regularly employed) _____

Was injured party 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 principle business function in DC _____ Employers Tel. 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:

Names of Witnesses _____

Nature and location of injury (describe fully): _____

Attending Physician and Address (If Hospital Involved--Indicate): _____

Name (Please Print or Type)

Signature

Name of Person Completing Form

Official Position