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 Number

Employer Identification Number

Insurer Number

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.

EMPLOYEE'S NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE

Employee Name And Address:	**Employer Name And Address:**	**Insurer Name And Address:**

NOTICE TO EMPLOYEE

YOU MUST FILE THIS REPORT WITHIN 30 DAYS AFTER YOU BECOME AWARE OF AN ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE AND ITS RELATIONSHIP TO YOUR JOB. ONE COPY SHOULD BE MAILED TO THE D.C. GOVERNMENT, OFFICE OF WORKERS' COMPENSATION AT THE ABOVE ADDRESS, ONE COPY SHOULD BE MAILED OR DELIVERED TO YOUR EMPLOYER, AND ONE COPY SHOULD BE RETAINED FOR YOUR RECORDS. IN ORDER TO PRESERVE YORU RIGHTS UNDER THE LAW, YOU MUST FILE A CLAIM FORM NO. 7A DCWC, WHICH CAN BE OBTAINED FROM YOUR EMPLOYER, FROM THE OFFICE OF WORKERS' COMPENSATION, OR FROM THE DEPARMTNET OF EMPLOYMENT SERVICES WEB SITE.

Date and Time of Injury: _____ am/pm?

Place where injury occurred: _____

Description of Injury: _____

THIS IS TO NOTIFY YOU_____

Employer

THAT I _____, while in your employ, sustained a disabling injury X or contracted an occupational disease __ as described above. The disability was caused by:

_____

_____

Treating Physician's Name and Address:

_____

_____

FORM NO. 7 DCWC

_____
(Employee's Signature)

(PART 1) – ORGINIAL OWC

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EMPLOYEE'S CLAIM APPLICATION

Employee Name And Address:	**Employer Name And Address:**	**Insurer Name And Address:**

NOTICE TO EMPLOYER/INSURER

A CLAIM FOR WORKERS COMPENSATION BENEFITS HAS BEEN FILED WITH THIS OFFICE. YOU HAVE 14 DAYS FROM THE RECEIPT OF THIS NOTICE IF YOU HAVE NO PREVIOUS KNOWLEDGE OF INJURY OR ITS RELATIONSHIP TO EMPLOYMENT, TO BEGIN VOLUNTARY PAYMENTS OF WORKERS COMPENSATION BENEFITS TO THE ABOVE NAMED EMPLOYEE, OR YOU MUST FILE A NOTICE OF CONTROVERSION, MEMO OF DENIAL OF BENEFITS, FORM NO. 11 DCWC WITH THIS OFFICE. FAILURE TO PAY BENEFITS, UNLESS YOU CONTROVERT THE EMPLOYEE'S RIGHT TO BENEFITS WILL BE SUBJECT YOU TO PENALTIES UNDER THE ACT. YOU SHOULD CONTACT YOUR INSURER IMMEDIATELY.

Date and Time of Injury: _____am/pm? Office Representative: _____

Place where injury occurred: _____

Description of Injury: _____

THIS IS TO NOTIFY YOU _____

Employer

That while in the employ of the above named employer I sustained a disabling injury __ or contracted an occupational disease __ as described above. The disability was caused by: _____

_____

Treating Physician's Name and Address: _____

_____

YOU SHOULD HAVE ALREADY FILED OR SHOULD FILE EMPLOYEE'S NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE, FORM NO. 7 DCWC.

I HAVE FILED THIS CLAIM WITH THE OFFICE OF WORKERS' COMPENSATION.

_____

(Employee's Signature)

FORM NO. 7A DCWC

(PART 2) – EMPLOYER COPY