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

(202) 576-6265

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.

EMPLOYEE'S
NOTICE OF ACCIDENTAL INJURY OR OCCUPATION 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. PART 1 SHOULD BE MAILED TO THE D.C. GOVERNMENT, OFFICE OF WORKERS' COMPENSATION AT THE ABOVE ADDRESS. PART 2 SHOULD BE MAILED OR DELIVERED TO YOUR EMPLOYER, AND PART 3 RETAINED FOR YOUR RECORDS. IN ORDER TO PRESERVE YOUR RIGHTS UNDER THE LAW, YOU MUST FILE A CLAIM FORM NO. 7a DCWC, A COPY OF WHICH CAN BE OBTAINED FROM YOUR EMPLOYER OR THE OFFICE OF WORKERS' COMPENSATION.

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 an injury ☐ or contracted an occupational disease ☐ as described above, caused by:

_____

Treating Physician's Name and Address: _____

_____

FORM NO. 7 DCWC

_____
(Employee's Signature)