

(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 of Person Completing Form

\_\_\_\_\_  
 Name (Please Print or Type)

\_\_\_\_\_  
 Signature

FORM NO. 8 DCWC

\_\_\_\_\_  
 Official Position