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

(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.

EMPLOYEE'S CLAIM APPLICATION

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

NOTICE TO EMPLOYEE

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 SUBJECT YOU TO PENALTIES UNDER THE ACT. YOU SHOULD CONTACT YOU INSURER IMMEDIATELY.

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

Place where injury occurred: _____

Description of Injury: _____

_____

THIS IS TO NOTIFY YOU _____

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 ACCIDENTIAL INJURY OR OCCUPATIONAL DISEASE, FORM NO. 7 DCWC.

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

FORM NO. 7A DCWC

_____
(Employee's Signature)