DISTRICT OF COLUMBIA GOVERNMENT
DEPARTMENT OF EMPLOYMENT SERVICES
OFFICE OF WORKERS' COMPENSATION

4058 MINNESOTA AVENUE, N.E.• WASHINGTON, DC 20019 • (202) 671-1000 • (202) 671-1929 (fax)

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. Penalities 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.

NOTICE OF COMPLIANCE

TO EMPLOYEES

1. You are required by law to report promptly to your employer and the Office of Workers' Compensation an occupational injury or disease, even if you deem it to be minor. Form No. 7 DCWC, Notice of Accidental Injury or Occupational Disease, to be obtained from the employer or the Office of Workers' Compensation, must be used for that purpose. After you have completed and signed it, you should mail it to the Office of Workers' Compensation at the above address, and to your employer.

2. You are entitled, if required, to the services of a physician or hospital of your choice and lost wages. Call (202) 671-1000 for information.

3. You may not sue your employer as a result of a work-connected injury or disease by reason of your exclusive remedy under the Workers' Compensation Law.

4. In order to preserve your right to benefits under the DC Workers' Compensation Law, you must file a written claim on Form No. 7A DCWC, Employee's Claim Application, within one (1) year after your injury, or within (1) year after the last payment of benefits.

5. If you desire information regarding your rights and obligations prescribed by law, you may call your employer first. If you need further information you may call the Office of Workers' Compensation at (202) 671-1000.

6. The law gives you the right to be represented if you so desire.

TO EMPLOYERS

1. You are required to have Workers' Compensation insurance coverage if you have 1 or more employees.

2. You are required to display this poster at each worksite so that it will be of the greatest possible benefit to your employees.

3. You must file an Employer's First Report of Injury or Occupational Disease, Form No. 8 DCWC, with the Office of Workers' Compensation, copy to the nearest claim office of your insurer, on all occupational injuries or disease, as soon as possible, but no later than 10 days after the date of knowledge thereof.

4. Your employee must file Form No. 7 DCWC, Employee's Notice of Accidental Injury or Occupational Disease. Please provide your employee with Form No. 7 DCWC and direct them to complete it and return it to you and the Office of Workers' Compensation. Once you have received notice from the employee, you are required to send the employee a notice of his/her rights and obligations by certified mail, return receipt requested.

5. You are required to report to the Office of Workers' Compensation, and your insurer, and disability of more than 3 days which was not previously reported, as soon as possible, but no later than 10 days after the date of knowledge thereof.

6. You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation, to an injured or disabled employee.

7. You are required to obtain from the insurer identified below a supply of all required Workers' Compensation Forms, or you may download the forms and notice mentioned above at our website http://does.dc.gov

NOTICE: Violation of the various provisions of the Workers' Compensation law provides for civil penalties.

The undersigned employer hereby gives notice of compliance with all provisions of the Workers' Compensation Law and Administrative Regulations

NAME OF INSURANCE COMPANY

Berkley Industrial Comp
P.O. Box 660847
Birmingham, AL 35266
(800) 448-5621

NAME OF EMPLOYER

BY ____________________

____

Employer ID Number
(if number unknown, employer to request from IRS)

THIS NOTICE IS TO BE POSTED CONSPICUOUSLY IN AND ABOUT EMPLOYER'S PLACE(S) OF BUSINESS

DISTRICT OF COLUMBIA WORK INJURY REPORTING PROCEDURES

This Claim Packet is provided for your use in reporting employee work related injuries. Copy the enclosed forms as needed.

Employer's First Report of Injury (Form No. 8 DCWC)

This form must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to us. As an alternative, Employer's First Reports of Injury (FROI's) may be submitted to us online at: **https://berkindcomp.com**. Online Reporting Instructions are enclosed. Maintain a copy of the FROI for your records. Keep a separate file for each workers' compensation claim.

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the FROI. If the FROI is reported online, then please mail, fax or e-mail the Supervisor's Report to us. Maintain a copy for your records. If you utilize another version of a supervisor's report, it may be substituted for the enclosed report.

Wage Statement (Form No. 10 DCWC)

Wage statements must be completed on claims involving lost time from work. The employee's gross wages for the 26 weeks prior to the date of injury are required. If the employee has not been employed for 26 weeks, then report the available wages. In addition to regular pay, computation of wages may include overtime, tips, and the reasonable value of food, housing and other benefits furnished by the employer without charge to the employee. If there are weeks with no wages, please explain the reason by coding as follows:

V= Vacation I= Illness L= Lay off P= Personal leave O= Other

Please contact our claims department with questions.

Do not delay reporting the Employer's First Report of Injury for completion of the wage statement.

Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. You must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

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Date of This Report ____________________

Employee Social Security No. ____________________

Employer Identification No. ____________________

Insurer No. ____________________

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 its employees, but no later than ten (10) days thereafter. Failure to file this form shall be subject to civil penalty not to exceed $1,000.

Date and time of Injury: ____________________am/pm? Day of the 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/time disability began? ____________________ am/pm? Was the injured paid in full for this day? ____________________

Was the injured given Form No. 7 DCWC? ☐ Yes ☐ No Foreman/Supervisor____________________

When did you or the foreman first learn of the injury? ____________________

☐ Male ☐ Female DOB: __________ Employee's Telephone No.: ____________________

Occupation when injured? ____________________ Was this his/her regular occupation?____________________

(Department or branch regularly employed): ____________________

Was the injured 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 principal business function in DC:____________________

Employer's Telephone 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 the body affected: ____________________

____

Name of Witnesses: ____________________

Nature and location of injury (Describe fully): ____________________

____

Attending Physician and Address (If Hospital Involved – Indicate):____________________

____

____
Name (Please Print or Type)

____
Name of Person Completing Form

____
Signature

____
Official Position

Employee's Rights and Obligations

District of Columbia Workers' Compensation Law

- You are required by law to promptly report your injury by filing DCWC Form 7, Employee's Notice of Accidental Injury or Occupational Disease, with your employer and the Office of Workers' Compensation within 30 days of the date of injury or the date you have knowledge that the injury is related to your job.

- In order to preserve your right to workers' compensation benefits under the law, you must file a written claim on DCWC Form 7a, Employee's Claim Application, within one (1) year after your injury, or within one (1) year after the last payment of benefits. Benefits include indemnity payments for lost wages, medical services and treatment, and vocational rehabilitation.

- Failure to properly file the Notice of Accidental Injury or Occupational Disease, DCWC Form 7 or the Employee's Claim Application DCWC Form 7a may bar your right to future compensation. Copies of these forms and other pertinent information are available on the Department of Employment Services, Office of Workers' Compensation's website. The website address is listed below.

- You may not sue your employer as a result of a work-related injury or disease, the Workers' Compensation law is your exclusive remedy.

- You have the right to choose a treating physician. Once you choose a treating physician you may not change physicians unless you get approval from your employer's insurance company or the Office of Workers' Compensation. Medical treatment includes medical services, supplies, prosthetic devices, and prescriptions. Medical services include treatment by a dentist, osteopath, podiatrist and chiropractor.

- Compensation is not paid for the first 3 days of disability unless the disability exceeds 14 days. Compensation is paid at the rate of 66 ⅔% of your average weekly wage. Unless your employer controverts your right to compensation within 14 days after he has knowledge of the injury, the 1st installment of compensation becomes due on the 14th day and must be paid within 14 days after it is due.

- You have the right to request an informal conference or a formal hearing on disputes arising on matters regarding your claim and you have the right to be represented by an attorney or other representative if you so desire.

- You may be entitled to vocational rehabilitation services if you are unable to return to the job you had prior to the injury.

- For injuries occurring on or after 4/16/99, disability benefits for any one (1) injury causing temporary or permanent partial disability shall be limited to 500 weeks. However, within 60 days of the expiration of the 500 week duration, an employee may petition the Mayor for an extension of up to 167 weeks.

- Your employer is required to advise you of your rights and obligations under the Workers' Compensation law and if you need further information, you may call the Office of Workers' Compensation on (202) 671-1000 or fax (202) 671-1929. The web address is http//does.dc.gov

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Date of This Report ____________________

Employee Social Security No. ____________________

Employer Identification No. ____________________

Insurer No. ____________________

Wage Schedule

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

Employer must forward to insurer copies of this schedule no later than employee's tenth (10th) day of loss of wages.

This wage schedule is for 26 weeks prior to date of injury, for wages fixed by week, month, or year, and must be filed with Office of Workers' Compensation by insurer, together with Form No. 9 DCWC, except when maximum compensation is paid. ***(Wages: In addition to money payments, wages mean reasonable value of board, rent, and housing that were received from employer as well as gratuities declared for tax purposes.)***

Date of Hire: __________________ Date of Injury: __________________

Hourly Wages: ________________ Average Weekly Earnings: _________________

	1	2		3	4
Week Ending	**Gross Earnings**	**Other Advantages** (see wages definition above)	**Week Ending**	**Gross Earnings**	**Other Advantages** (see wages definition above)
1			**14**		
2			**15**		
3			**16**		
4			**17**		
5			**18**		
6			**19**		
7			**20**		
8			**21**		
9			**22**		
10			**23**		
11			**24**		
12			**25**		
13			**26**		

Total of columns 1,2,3 and 4 ______________________________

If wages fixed by week, month, or year, state amount ____________________ **per** ___________________________

______________________________ Representatives Name

______________________________ Signature