EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

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<th>Employee Name and Address:</th>
<th>Employer Name and Address:</th>
<th>Insurer Name and Address:</th>
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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 _________________________________
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): __________________________________________________________

__________________________________________________________________________________________________________________

Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

Name (Please Print or Type)

______________________________

Name of Person Completing Form                  Signature

______________________________

Official Position

Form No. 8 DCWC  9-2491

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.