DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKERS' COMPENSATION
P.O. BOX 56098
WASHINGTON, DC 20011
(202) 576-6265

Date of This Report

Employee Social Security No.

53-0196584
Employer Identification No.

1071
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.

EMPLOYEE'S
NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:
	George Washington University Office of Risk Management 2025 F Street, NW Suite #101 Washington, DC 20052	Self-Insured

NOTICE TO EMPLOYER/INSURER:

YOU MUST FILE THIS REPORT WITHIN 30 DAYS AFTER YOU BECOME AWARE OF AN ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE AND ITS RELATIONSIP TO YOUR JOB. PART 1 SHOULD BE MAILED TO THE D.C. GOVERNMENT, OFFICE OF WORKERS' COMPENSTION 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 UDER THE LAW, YOU MUST FILE A CLAIM FORM NO. 7a DCWC, A COPY OF WHICH CAN BE OBTAINED FROM YOUR EMPLOYER, FROM THE OFFICE OF WORKERS' COMPENSATION, OR FROM THE DEPARTMENT OF EMPLOYMENT SERVICES WEB SITE.

Date and Time of Injury _____ **am/pm?**

Place where injury occurred: _____

Description of Injury: _____

_____

THIS IS TO NOTIFY YOU The George Washington University
Employer

THAT I _____**, while in the employ, sustained a disabling injury ( ) or contracted an occupational disease ( ) as described above, caused by:**

_____

_____

Treating Physician's Name and Address

_____

_____

_____
(Employee's Signature)