FRANKLIN & PROKOPIK
A PROFESSIONAL CORPORATION
ATTORNEYS AT LAW

2 N. Charles Street, Baltimore, MD, 21201 / 410.752.8700 T / 410.752.6868 F / www.fandpnet.com

DISTRICT OF COLUMBIA Workers' Compensation Key Forms and Dates

District of Columbia
Workers' Compensation Claims
Key Forms and Dates

1. Employee's Notice of Accidental Injury or Occupational Disease (DCWC No. 7) (Exhibit No. 1)
    - Filed by Claimant with the OWC and with Employer
    - Identifies Employer, specifies injury and average weekly wage ("AWW") claimed, etc.
    - Should be filed with OWC within 30 days of injury.
    - This form is available in Spanish and is entitled "Notificación del Empleado Sobre un Daño Accidental o Una Enfermedad por Razones Laborales."

2. Employee's Claim Application (DCWC No. 7A) (Exhibit No. 2)
    - Sent by Claimant along with Form 7 to both OWC and Employer.
    - Must be filed within 1 year of injury or death, but 1 year clock is forgiven if Employer has not filed Form No. 8.
    - Employer must then either pay benefits and file Memo of Payment, DCWC No. 9, or file Notice of Controversion, DCWC No. 11, within 14 calendar days.
    - This form is available in Spanish and is entitled "Solicitud de Reclamación del Empleado."

3. Employer's First Report (DCWC No. 8) (Exhibit No. 3)
    - Filed by employer upon notice of alleged work related injury.
    - Does <u>not</u> constitute filing a claim nor is it evidence of truth of Claimant's allegations.
    - Starts limitations running for indemnity benefits
    - Will <u>not</u> trigger a hearing or Award

4. Memo of Payment (DCWC No. 9) (Exhibit No. 4)
    - Filed with initial payment of compensation, following the issuance of a Compensation Order or when any new period of compensation begins.
    - Can file with a provisional payment if the Claimant's alleged Average Weekly Wage is incorrect.

5. Wage Schedule (DCWC No. 10) (Exhibit No. 5)
    - District of Columbia law requires 26 weeks to be used in calculating compensation.
    - Should be filed with Memo of Payment or Notice of Controversion. If filed later, new Memo of Payment or Notice of Controversion should be filed with the Wage Statement.

6. Notice of Controversion/Memo of Denial of Workers' Compensation Benefits (DCWC No. 11) (Exhibit No. 6)
    - Used for both initial denial of claim and for subsequent termination of benefits.

7. Memo of Payment (Exhibit No.7)
    - Filed to notify that TTD has been initiated.

8. Notice of Final Payment (DCWC No. 15) (Exhibit No. 8)
    - Filed when terminating payments for any reason.
    - If terminating payments for a contested reason, must also file Notice of Controversion.

9. Application for Informal/Mediation Conference (Exhibit No. 9)
    - Informal Conference Notice will be generated in 2 to 3 weeks.

10. Memorandum of Informal Conference (Exhibit No. 10)
    - Findings of fact and recommendations issued by Claims Examiner following Informal Conference.
    - Either party may notify the Claims Examiner in writing within 14 business days that it is accepting or rejecting the recommendation. If no party takes any action, the Claims Examiner will convert the recommendation into a Final Order. If a party rejects the recommendation, it must file a Request for Formal Hearing within 34 business days. The recommendation is then null and void.

11. Stipulation (Exhibit No. 11)
    - Avoids hearing, but does <u>not</u> automatically close any aspect of claim
    - OWC will issue Final Order approving Stipulation.
    - Claimant's attorney's fees are deducted from Final Order and are specified in the body of the Stipulation.

12. Petition for Lump Sum Settlement (Exhibit No. 12)
    - Can have a "full and final" settlement, with or without "closed medicals", but must be approved by OWC (form Order approving)
    - Claimant's attorney's fee is deducted from total settlement amount and specified in the Petition.
    - Unlike Stipulation, forever closes all aspects of claim once approved by OWC, unless medicals are left open.

13. Application for Formal Hearing (OWC-20) (Exhibit No. 13)

14. Employee's Rights and Obligations Information Sheet (Exhibit No. 14)

15. Workers' Compensation Notice of Compliance, Employer Form (No. 1 DCWC) (Exhibit No. 15)

Exhibit 1

DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKERS' COMPENSATION
4058 MINNESOTA AVENUE, N.E.
WASHINGTON, D.C. 20019

(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
NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE

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

NOTICE TO EMPLOYEE

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

Date and Time of Injury: _____ am/pm?

Place where injury occurred: _____

Description of Injury: _____

_____

THIS IS TO NOTIFY YOU _____
(Employer)

THAT I _____ while in your employ sustained an injury ☐ or contracted an occupational disease ☐ as described above caused by:

_____

Treating Physician's Name and Address: _____

_____

_____
(Employee's Signature)

District of Columbia Government
Office of Workers' Compensation
P. O. Box 56098
Washington, DC 20011
(202) 671-1000

Fecha de este informe

N° del seguro social del empleado

N° de identificación del empleador

N° de la compañía aseguradora

Advertencia: Es un delito proporcionar información falsa o que induzca a error a la compañía aseguradora con la intención de defraudar a la misma o a una persona. La pena que se impondrá será de prisión y/o multas. Además, la compañía aseguradora podrá denegar prestaciones si la información falsa, respecto a una reclamación, fuera proporcionada por el solicitante de la misma

NOTIFICACIÓN DEL EMPLEADO SOBRE UN DAÑO ACCIDENTAL O UNA ENFERMEDAD POR RAZONES LABORALES

Nombre y dirección del empleado:	Nombre y dirección del empleador:	Nombre y dirección de la compañía aseguradora:

NOTIFICACIÓN AL EMPLEADO

Usted debe enviar este informe antes de 30 días a partir de la fecha en que tiene conocimiento de haber sufrido un daño accidental o una enfermedad y que está relacionado con su trabajo. La parte 1 se deberá enviar por correo al gobierno de D.C., oficina del seguro de accidentes laborales (*Workers' Compensation*), a la dirección que se muestra en la parte superior de este documento. La parte 2 se deberá enviar por correo, o entregar directamente, a su empleador y la parte 3 la deberá guardar usted. Para poder retener sus derechos bajo la ley, deberá presentar una reclamación, formulario 7 DCWC, cuya copia se puede obtener por medio de su empleador o en la oficina del seguro de accidentes laborales.

Fecha y hora (mañana, tarde o noche) de la lesión _____
Lugar donde ocurrió: _____
Descripción de la lesión: _____

El presente documento es para notificar a _____
Empleador

Que yo_____, cuando era empleado en dicha empresa,
sufrí una lesión ☐ o contraje una enfermedad debido a mi trabajo ☐ como he descrito anteriormente y fue causada por:

Nombre y dirección del médico que le atendió: _____

_____
(Firma del empleado)

(PART 1) ORIGINAL CWC

Exhibit 2

DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKERS' COMPENSATION
4058 MINNESOTA AVENUE, N.E.
WASHINGTON, D.C. 20019

(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)

District of Columbia Government
Office of Workers' Compensation
P. O. Box 56098
Washington, DC 20011
(202) 671-1000

Fecha de este informe _____

Nº del seguro social del empleado _____

Nº de identificación del empleador _____

Nº de la compañía aseguradora _____

Advertencia: Es un delito proporcionar información falsa o que induzca a error a la compañía aseguradora con la intención de defraudar a la misma o a una persona. La pena que se impondrá será de prisión y/o multas. Además, la compañía aseguradora podrá denegar prestaciones si la información falsa, respecto a una reclamación, fuera proporcionada por el solicitante de la misma

SOLICITUD DE RECLAMACIÓN DEL EMPLEADO

Nombre y dirección del empleado:	Nombre y dirección del empleador:	Nombre y dirección de la compañía aseguradora:

NOTIFICACIÓN AL EMPLEADOR Y A LA COMPAÑÍA ASEGURADORA

Se ha presentado una reclamación para obtener prestaciones bajo el seguro de accidentes laborales (*Workers' Compensation*). Usted tiene 14 días a partir de la fecha en que reciba esta notificación, si no ha sido ya notificado previamente sobre una lesión o su relación con el trabajo del empleado, para comenzar pagos voluntarios de prestaciones bajo el seguro de accidentes laborales al empleado nombrado anteriormente en este documento, o deberá presentar en esta oficina una notificación de controversia, *Informe de denegación de prestaciones*, formulario Nº 11 DCWC. Si no paga las prestaciones, a no ser que contradiga el derecho del empleado a los mismos, se le impondrá las consecuencias que dicta la ley. Debe ponerse en contacto con su compañía aseguradora inmediatamente.

Fecha y hora (mañana, tarde o noche) de la lesión : _____
Representante de la oficina: _____
Lugar donde ocurrió la lesión: _____
Descripción de la lesión: _____

El presente documento es para notificar a _____

Que cuando era empleado en la compañía nombrada anteriormente, sufrí una lesión incapacitante □ o contraje una enfermedad debido a mi trabajo □ como he descrito anteriormente. La discapacidad fue causada por:

Nombre y dirección del médico que le atendió: _____

Ya ha tenido que presentar o debe presentar la *Notificación del empleado sobre un daño accidental o una enfermedad por razones laborales*, formulario Nº 7 DCWC.		He presentado la reclamación en la oficina del seguro de accidentes laborales (*Workers' Compensation*).

_____
(Firma del empleado)

Form 7A DCWC

(Spanish)

Exhibit 3

District of Columbia Government
Office of Workers' Compensation
4058 Minnesota Avenue, N.E.
Washington, DC 20019
(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.

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

Form No. 8 DCWC 9-2491

Exhibit 4

District of Columbia Government
Office of Workers' Compensation
4058 Minnesota Avenue, N.E.
Washington, DC 20019
(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.

Memo of Payment of Workers' Compensation

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

The employer is required to pay disability compensation and to file with the Office of Workers' Compensation (OWC), copy to employee, memorandum of payment in accordance with Section 16, *as soon as possible after date of knowledge of injury, but by the fourteenth day thereafter*. Filling shall also be made upon making provisional payment, adjusting such payment, and upon making payment resulting from an OWC award. Failure to pay and to file memoranda promptly, in the absence of a legitimate denial of benefit, shall subject the employer to an added ten percent (10%) of payment.

Date and time of Injury: _____

Description of Injury: _____

	Disability/Recurrence	First Supplemental Report- Received Date	1st Payment	2nd Payment
Date				

Compensation at the rate of $ _____per week. Average weekly wage of $ _____.

Beginning _____

Compensation payment voluntary	☐ Yes ☐ No
Compensation payment results from OWC hearing award	☐ Yes ☐ No
Memo indicating provisional payment already filed	☐ **Yes** ☐ **No**
Memo indicating adjustment in total disability	☐ **Yes** ☐ **No**

See attached wage schedule, except if maximum compensation or disability is less than seven (7) days.

Missing wage schedule ☐ Yes ☐ No

When expected? _____ Provisional Payment of $ _____, subject to later adjustment.

_____
Name (Please Print or Type)

_____
Office Approval & Date

_____
Signature

_____
Telephone Number

Exhibit 5

District of Columbia Government
Office of Workers' Compensation
4058 Minnesota Avenue, N.E.
Washington, DC 20019
(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.

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

Exhibit 6

District of Columbia Government
Office of Workers' Compensation
4058 Minnesota Avenue, N.E.
Washington, DC 20019
(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.

Notice of Controversion
Memo of Denial of Workers' Compensation

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

Date of Accident: _____

Date First Report Received:_____

YOUR WORKERS' COMPENSATION BENEFITS ARE HEREBY DENIED BY EMPLOYER OR INSURER FOR REASON(S) INDICATED BELOW. IF YOU DISAGREE, YOU MAY APPPLY FOR A HEARING BY COMPLETING FORM NO. 20 (ON THE REVERSE).THE HEARING WILL BE SCHEDULED WITHIN 20 WORKING DAYS AFTER RECEIPT OF THIS NOTICE. IN THE INTERIM, IF YOU WISH TO PARTICIPATE IN AN INFORMAL CONFERENCE, YOU MAY CALL 202-671-1000 OR WRITE THE DIRECTOR AT THE ADDRESS ABOVE. YOU MAY BE REPRESENTED AT SUCH PROCEEDINGS IF YOU SO DESIRE, AND YOU WILL BE ADVISED IN WRITING OF THE PLACE, DATE AND TIME. IF YOU HAVE NOT ALREADY FILED AN EMPLOYEE'S CLAIM APPLICATION, FORM NO.7a DCWC, YOU MUST DO SO WITHIN ONE (1) YEAR OF THE DATE OF INJURY OR ONE (1) YEAR AGTER THE LAST PAYMENT OF COMPENSATION BENEFITS BY YOUR EMPLOYER.

REASONS

1. ❑ **No Employer- Employee Relations**
2. ❑ **No Casual Relationship to Employment**
3. ❑ **Improper Notice of Injury by Employee**
4. ❑ **Continuing Disability Contested**
5. ❑ **No Jurisdiction Under D.C. Law**
6. ❑ **Other**

Explanation:_____
_____
_____
_____
_____
_____

Authorized Representative _____

❑ **INITIAL DENIAL** ❑ **SUBSEQUENT DENIAL**

THE DISTRICT OF COLUMBIA GOVERNMENT

DEPARTMENT OF EMPLOYMENT SERVICES

OFFICE OF WORKERS' COMPENSATION

4058 MINNESOTA AVENUE, N.E. • WASHINGTON, D.C. 20019 (202) 671-1000

APPLICATION FOR FORMAL HEARING

CLAIMANT: _____

EMPLOYER: _____

INSURANCE COMPANY: _____

DATE OF INJURY: _____

THIS IS TO ADVISE YOU A HEARING IS REQUESTED PURSUANT TO SECTION 26, D.C. LAW 3-177.

PLEASE NOTIFY ME OF THE SCHEDULED DATE AT THE FOLLOWING ADDRESS.

_____

NAME OF REQUESTER

_____

NAME OF FIRM, COMPANY OR ORGANIZATION, IF ANY

_____

ADDRESS ZIP CODE

_____

DATE

IF REQUESTER IS REPRESENTING CLAIMANT OR ANOTHER PARTY, SO INDICATE HERE: _____

FORM NO.20 DCWC

Exhibit 7

District of Columbia Government
Office of Workers' Compensation
4058 Minnesota Avenue, N.E.
Washington, DC 20019
(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.

Memo of Payment of Workers' Compensation

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

The employer is required to pay disability compensation and to file with the Office of Workers' Compensation (OWC), copy to employee, memorandum of payment in accordance with Section 16, *as soon as possible after date of knowledge of injury, but by the fourteenth day thereafter*. Filling shall also be made upon making provisional payment, adjusting such payment, and upon making payment resulting from an OWC award. Failure to pay and to file memoranda promptly, in the absence of a legitimate denial of benefit, shall subject the employer to an added ten percent (10%) of payment.

Date and time of Injury: _____

Description of Injury: _____

	Disability/Recurrence	First Supplemental Report- Received Date	1st Payment	2nd Payment
Date				

Compensation at the rate of $ _____per week. Average weekly wage of $ _____.

Beginning _____

Compensation payment voluntary	☐ Yes ☐ No
Compensation payment results from OWC hearing award	☐ Yes ☐ No
Memo indicating provisional payment already filed	☐ **Yes** ☐ **No**
Memo indicating adjustment in total disability	☐ **Yes** ☐ **No**

See attached wage schedule, except if maximum compensation or disability is less than seven (7) days.

Missing wage schedule ☐ Yes ☐ No

When expected? _____ Provisional Payment of $ _____, subject to later adjustment.

_____
Name (Please Print or Type)

_____
Office Approval & Date

_____
Signature

_____
Telephone Number

Exhibit 8

District of Columbia Government
Office of Workers' Compensation
4058 Minnesota Avenue, N.E.
Washington, DC 20019
(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.*

NOTICE OF FINAL PAYMENT OF COMPENSATION PAYMENTS

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

INSTRUCTIONS: This notice must be filed with the Office of Workers' Compensation, P.O. Box 56098, Washington, D.C. 20011, within 16 days after compensation has ended, subject to civil penalty.

Date and time of Injury: _____ Date of Last Payment: _____
Date employee returned to work: _____ Date employee lost pay because of injury: _____
Date employee able to return to work, per physician's report of work ability: _____
Was compensation paid at the maximum rate? ❑ Yes ❑ NO

Average weekly wage $_____ multiplied by 2/3 = Compensation rate $_____

State reasons for ending of payments:

Enter All Disability Payments

TYPE OF DISABILITY	FROM (mo-day-yr)	To (mo-day-yr	AMT. PAID PER WEEK	NO. OF WEEKS PAID	TOTAL
Temporary total					
Temporary partial Permanent Partial (non-schedule)					
Permanent Partial (Schedule loss, facial or other disfigurement)	Percent	Part of Body			
				Total	**$**

ENTER OTHER PAYMENTS

a. Attorney fees _____ **b. Penalty for late payment _____**	**c. Interest _____**	**TOTAL:**

Name of insurance carrier or self- insured employer

Signature of person authorized to sign for carrier | **TITLE**

EMPLOYEE PLEASE READ CARFULLY	**If you have any permanent impairment of the body or other disability from the injury for which you have not received compensation, you should inform the Director at the above address of same, and request Form No. 7a DCWC in order to preserve your claim and rights under the law.**

Exhibit 9

Government of the District of Columbia
Department of Employment Services

Office of Workers' Compensation | **4058 Minnesota Avenue, N.E.** | **Washington, D.C. 20019**

APPLICATION FOR INFORMAL / MEDIATION CONFERENCE

Name of party on whose behalf this application is submitted: _____

OWC No.: _____

Date of Injury: _____

- **IF THE PARTY APPLYING FOR INFORMAL CONFERENCE IS REPRESENTED AND THE REPRESENTATIVE HAS NOT ENTERED HIS / HER APPEARANCE, A COPY OF THE REPRESENTATIVE'S AUTHORIZATION MUST BE ATTACHED TO THIS APPLICATION.**

Claimant name, address, and phone number: _____

_____

Claimant representative's name, address, and phone number: _____

_____

Employer name, address, and phone number: _____

_____

Carrier name, address, and phone number: _____

_____

Employer/Carrier representative's name, address, and phone number: _____

_____

ISSUES TO BE DISCUSSED: _____

_____

_____

_____

Employer/Carrier Position: _____

_____

_____

_____

Signature of Party Requesting Conference

Informal procedures may include informal conferences and mediation conferences provided that participation by interested parties in these conferences is voluntary. Informal conferences shall be held at the Office or by telephone. A statement supporting good cause must be attached to the Application. The Associate Director and/or Supervisor will make the final decision.

One major purpose of the informal conference is to amicably dispose of controversies, whenever possible. It is a requirement that: all pertinent written / documentation (i.e.) (factual, medical, etc.) shall be provided to the office and exchanged among all parties at the earliest possible date, or at least 48 hours prior to the commencement of the conference. [This process serves to assist in ensuring an expeditious resolution of controversies.]

Exhibit 10

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Employment Services

ADRIAN M. FENTY
MAYOR

JOSEPH P. WALSH
DIRECTOR

OFFICE OF WORKERS' COMPENSATION

JUN 16 2010

MEMORANDUM OF INFORMAL CONFERENCE

Claimant: [redacted] OWC NO. [redacted]
Employer: [redacted]
Insurance Carrier: [redacted]

Date of Conference: June 7, 2010
Nature of Injury: Back, Left Hip and Left Leg
Date of Injury: January 7, 2010
Record Closed: June 11, 2010

Appearances: Claimant present: Yes
For Claimant: [redacted]
For Employer/Carrier: [redacted]
Issue(s) in dispute: Workers' Compensation benefits and Medical Expenses

Employee's Claim: Claimant seeks benefits under the Act for payment of all causally related medical expenses as a result of her injury on January 7, 2010.

Documentation/Support of Claim: Claimant submitted the following documents as evidence in support of their claim: multiple medical reports chronicling the treatment and progress of the injury; and medical bills.

Employer/carrier Position: Not in the Scope of Employment (applying "coming or going rule")

Documentation/Support of Position: Counsel for the employer/carrier submitted the following documents as evidence in support of their claim: Follow up Office Notes, [redacted], M.D.; Emergency Room Records, Howard University Hospital; Investigative Report, SKI investigations; Recorded Statement, [redacted]; and Recorded Statement, [redacted]

Average weekly wage:
As stipulated by parties:

Compensation rate:
As recommended by examiner:

Upon discussion of the issues involved, together with due consideration to all information in the administrative file, the following recommendation is made.

Statement of Facts: I find, that on January 7, 2010, an employer/employee relationship existed as defined by the Act; that on that date claimant sustained an accidental injury; that there is jurisdiction for this claim under the Act; that claimant gave timely notice of the injury to employer; that claimant filed a timely claim for benefits; that employer filed a timely notice of controversion; that claimant's average weekly wage was $734.31; and, that claimant returned to her pre-injury employment on or around January 15, 2010.

JUN 16 2010

Background: [redacted] (hereinafter "the claimant") a 44-year old female, is employed as an office manager for [redacted] (Funeral Homes/Funeral Services) located at [redacted], Washington, D.C. Claimant works full-time from 9 a.m. to 6 p.m. Claimant stated that in addition to her office duties, sometimes she is assigned to travel to and from the Vital Records Office located at 825 North Capital Street, NE, Washington, D.C., to file and/or pick up Death Certificates. She also stated that the employer reimburses your mileage when filed.

On the morning of her accident, claimant was assigned to pick up death certificates at the Vital Records office. Claimant alleged, between 12 – 1 p.m., she parked and left her car but before she reached the Vital Records building she was struck and knocked to the pavement by a delivery car injuring her back, left hip and left leg. By way of ambulance, she was taken to the emergency room at Howard University Hospital, where she was treated, instructed to follow up with an orthopedic specialist, and released. She returned to work on January 8, 2010 (for less than ½ a day). She sought medical treatment from [redacted] M.D. for pain and discomfort. Physical Therapy was recommended and on January 13, 2010, Dr. [redacted] reported that claimant can return to some form of light duty on January 14th or 15th. The claimant stated that there was no wage loss; however, she is seeking payment for medical expenses.

A notice of controversion dated January 29, 2010 was received in this Office which stated that the reason was lack of medical.

Conclusion: Under the Act, a claimant is afforded the presumption that his/her injury arose out of and in the course of the employment if he/she presents credible evidence of a work related event or activity that has the potential to cause or contribute to the disability. In order to rebut the presumption the employer/carrier must present evidence comprehensive enough to sever the connection between the employment and the disability.

Counsel for the employer/carrier made reference to *Lewis v. WMATA*, H&AS No. 84-238 (Aug. 26, 1985) and *Marjorie A. Newton v. National Older Workers Career Center*, OHA No. 93-321, and primarily relied on the "coming and going rule," which stands for the proposition that injuries sustained away from the work site, while an employee is en route to or from work, do not occur in the course of employment.

The general rule in this jurisdiction is that injuries sustained while a claimant is going to or coming from work are not compensable, in that they do not arise out of or occur in the course of employment, and are thus not included in the definition of "injury" contained in the District of Columbia Workers' Compensation Act of 1979, as amended, Section 32-1501 which states "injury means accidental injury or death arising out of and in the course of employment...". See McKinley v. District of Columbia Dept. of Employment Services, 696 A.2d 1377 (D.C.App. 1997), citing Grayson v. District of Columbia Dept. of Employment Services, 516 A.2d 909 (D.C. 1986). The exceptions to the general rule include an employee shown to be on a special errand for employer, a part of which errand or mission involves travel to or from employer's work site or premises; or where an accident occurs while the claimant is traveling to or from work and employer provided transportation or where employer requires claimant to have a vehicle available for work purposes, and claimant is injured commuting in that vehicle. If claimant falls

in any of the categories above, claimant's injury may be found to be in the course of her employment because employer obtains some special benefit or imposes some special hazard from the method of commute. I find and conclude that the claimant's injury was sustained in the course of employment, since she was assigned by her employer to pick up the death certificates and considered on duty. She was injured as she was serving a business purpose.

Recommendation: It is hereby recommended that the employer be responsible for the payment of all medicals submitted to date, as it relates to the January 7, 2010 injury ([redacted]). Lastly, it is also recommended that the employer's payment of medical bills be in accordance to the fee schedule determined in the District of Columbia Workers' Compensation Act of 1979, §32-1507(b) (5). This fee schedule shall be based on 113% of Medicare's reimbursement amounts.

Attorney's Fee:

Action by Employer/Carrier or Claimant

The insurance carrier or self-insured is to submit Form 9 DCWC, showing compliance with the above recommendation. Upon completion of payment, a final Form 15 DCWC is to be submitted. To avoid statutory penalties all required forms should be sent to this office promptly and within fourteen (14) working days as required by the Act. In the event of noncompliance or disagreement with this recommendation, an aggrieved party (Claimant or Employer/Carrier) may apply for a formal hearing to be scheduled by completing Form No. 20 DCWC, Application for Formal Hearing.

Claims Examiner

Date: JUN 16 2010

Re: [redacted]
OWC No: [redacted]

JUN 16 2010

APPEAL RIGHTS

In accordance with Title 7 DCMR, Section 219.20, the parties shall have fourteen (14) working days after receipt of the Memorandum of Informal Conference within which to signify in writing whether they agree or disagree with the recommendation. If the parties agree with the Memorandum of Informal Conference, the parties shall prepare, and submit to the Office within fourteen (14) working days, a joint statement signed by the parties indicating their acceptance of the terms of the Memorandum and their intent to be bound by the terms. The Office shall issue a Final Order consistent with the provisions in Title 7 DCMR, Section 219.16.

If either party disagrees with the Memorandum, that party must file an application for a formal hearing in accordance with Title 7 DCMR, Section 220 within thirty-four (34) working days after the issuance of the Memorandum of Informal Conference. If an application is not filed, said Memorandum shall become final. Thereafter, the Office shall issue a Final Order that shall be sent by certified mail to the parties and their representatives, and the Hearings and Adjudication Section. An aggrieved party may request a review by the Director, DOES.

An application for a hearing must be addressed to:

ORIGINAL TO: Chief of the Office of Hearings and Adjudication
64 New York Avenue, NE
Washington, D.C. 20002
Phone (202) 671-2233

COPY TO: Charles L. Green
Associate Director
Labor Standards
64 New York Avenue, NE
Washington, D.C. 20002

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Employment Services

ADRIAN M. FENTY
MAYOR

[redacted]

JOSEPH P. WALSH
DIRECTOR

OFFICE OF WORKERS' COMPENSATION

Re: [redacted]

OWC No: [redacted]

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Memorandum of Informal Conference was mailed on JUN 16 2010 to the following:

[redacted] First Street, N.E.
Washington, D.C. 20011
CLAIMANT — CERTIFIED

LAW OFFICE OF FRANKLIN & PROKOPIK
[redacted]
2 North Charles Street, Suite 600
Baltimore, MD 21201
ATTORNEY FOR EMPLOYER/CARRIER — CERTIFIED

[redacted] Claims Adjuster
[redacted]
[redacted]
[redacted]
INSURANCE CARRIER

Claims Examiner

Exhibit 11

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF EMPLOYMENT SERVICES
OFFICE OF WORKERS' COMPENSATION PROGRAMS
P.O. BOX 56098
WASHINGTON, D.C. 20011

RE: OWC No. 600000
Claimant: Rose Bush
Employer: Associated Services
Insurer: ABC Insurance Co.
D/O/A: January 9, 2009

STIPULATION AND AGREED ORDER

COME NOW, the Claimant, Rose Bush, by and through her undersigned counsel, and the Employer, Associated Services, and Carrier, ABC Insurance Company, by and through their undersigned counsel, and hereby stipulate to the following agreed award:

1. On or about January 9, 2009, the Claimant, Rose Bush, sustained injuries to her right and left knees arising out of and in the course of her employment with Associated Services.

2. At the time of this injury, the Employer was insured by ABC Insurance Company.

3. The Claimant's average weekly wage on the date of the injury was $394.89, entitling her to a weekly compensation rate of $263.26 per week.

4. The Claimant received voluntary payments of temporary total disability benefits from January 10, 2009 to April 3, 2009 and from July 30, 2009 to October 7, 2009. The Employer/Carrier has also made payment on all appropriate related medical expenses.

5. Claimant received his medical care from Dr. Buster Neecap. Copies of relevant reports are attached herewith for the reviewer's convenience.

6. The Claimant has been evaluated by Dr. Ima Doctor on behalf of the Claimant who has provided a rating of 54% permanent partial disability to each knee. The Claimant has been evaluated by Dr. Ima Doctoo on behalf of the Employer/Carrier who has provided a rating of 25% permanent partial disability to each knee.

7. At issue between the parties is the nature and extent of Claimant's permanent disability to the right and left knees.

8. Considering all of the above, the Claimant and Employer/Carrier have agreed that the Claimant is entitled to a stipulated award of 42% permanent partial disability to each the right and left legs, for a total of 181.44 weeks of compensation at the rate of $263.26 per week, for a total of $47,765.90.

9.The parties further agree that our of the stipulated award, Claimant's Counsel, Esq. is entitled to an attorney's fee of $8,250.00 plus expenses and advances in the amount of $1,209.00, which includes the disability rating invoice of Ima Doctor, M.D.

10. The parties hereby agree to this stipulated award by their signature below.

Respectfully submitted,

_____

Rose Bush
Claimant

_____

Claimant's Counsel, Esq.
Counsel for Claimant

_____

Employer/Carrier's Counsel, Esq.
Counsel for Employer/Insurer

SO ORDERED:

_____

Claims Examiner

Exhibit 12

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

FLASH GORDON	)	
	)	
Claimant	)	**OWC NO. 123456**
	)	
v.	)	
	)	
EMPLOYER	)	
	)	
Employer	)	
	)	
and	)	
	)	
ABC INSURANCE	)	
	)	
Carrier	)	

* * * * * * * * * * * * *

PETITION FOR APPROVAL OF LUMP SUM SETTLEMENT AGREEMENT

COME NOW the parties to the above-referenced workers' compensation claims, by and through their undersigned attorneys, and pursuant to the District Of Columbia Workers' Compensation Act, §32-1508 hereby request that the Office of Workers Compensation approve an Agreement of Final Compromise and Settlement, and as grounds state:

1. The Claimant suffered a compensable injury to his right side on October 29, 2010 which resulted in a painful right inguinal hernia. Claimant asserts that his injury arose out of and in the course of his employment with ABC Company, Inc. as Property Superintendent.

2. The Claimant and Employer aver that jurisdiction for this claim exists in the District of Columbia because the Claimant regularly worked in the District of Columbia and his work-related injury occurred in the District of Columbia.

3. In treatment of his injuries, the Claimant saw various providers including Dr. Bruce Lee and received medical treatment, including surgical repair of his right inguinal hernia.

4. At the time of the aforesaid injury, the Claimant had an average weekly wage of $778.85 with a corresponding temporary total disability compensation rate of $519.24 per week.

5. The Claimant alleges that he continues to have functional limitations related to his right sided injury which affect his ability to work in his pre-injury occupation. Conversely, the Employer adamantly denies that claimant has ongoing disability. The Employer contests the nature and extent of claimant's injuries, the medical necessity and causal relationship of Claimant's continuing medical care, his entitlement to future temporary total disability benefits after release from care by Dr. Lee.

6. Taking all of the foregoing into consideration, the parties have agreed to a comprehensive resolution of these claims by a lump sum payment. In consideration of all circumstances outlined herein, the Employer has agreed to pay, and the Claimant has agreed to accept, a lump sum in the amount of Nine Thousand Dollars ($9,000.00) in full and final settlement of his claim for workers' compensation benefits pertaining to the occupational injury of October 29, 2010. The final settlement amount herein includes the sum of $4,000.00 which Employer agreed to pay to Claimant in advance of the approval of this petition but is not subject to any other credits or set-offs or any other sums previously paid, if any, from any source.

7. The parties further agree that this settlement is being made with prejudice to claimant's right to continue to receive medical treatment at the expense of the employer for any condition which is causally related to his occupational injury of October 29, 2010. The

Employer shall be responsible for all causally related, reasonable and necessary, costs of any medical services or care or benefits incurred prior to April 27, 2011 which are related to the October 29, 2010 injury. The Employer will not be responsible for the costs of any medical services or care or benefits incurred after April 27, 2011.

8. The parties hereby acknowledge and have considered the potential impact of the Medicare as Secondary Payer statute, 42 U.S.C. § 1395yy(b), on lump sum settlements that purport to release employer and insurers from liability for future medical expenses and further state that this claim constitutes a "contested" claim within the meaning of said statute. The parties further acknowledge that if Medicare's interest in the lump sum payment is not adequately considered per 42 C.F.R. § 411.46, Medicare may refuse to make medical payments once the claimant becomes entitled to Medicare benefits. Furthermore, the parties acknowledge if Medicare makes conditional payments of medical expenses that the Center for Medicare and Medicaid Services ("CMS") determines should have been paid by the primary payer, the CMS has the authority to seek reimbursement for those conditional payments, as well as interest, from virtually any entity involved in the claim. Finally, CMS may continue to hold employer and insurers responsible for future Medicare payments if medical expenses are compromised without approval of the settlement by CMS. In consideration of the above, Claimant hereby acknowledges that he is not entitled to Medicare benefits on account of either age or disability; nor have any Medicare benefits been paid in connection with the claim referenced herein. Mr. Gordon agrees and acknowledges that Medicare has not paid for any of his treatment related to these accidents. he further agrees and acknowledges that he is not now receiving Social Security

Disability or Medicare benefits and does not have a reasonable expectation of receiving either of these benefits within thirty (30) months of this settlement. The Claimant also acknowledges and understands that should he receive any further treatment related to these injuries, he cannot seek to transfer the costs of such treatment onto Medicare.

9. The parties believe that this settlement is being made in the Claimant's best interest.

10. The Claimant has been fully advised of his rights under the Act and is fully aware that the approval of this agreed settlement will discharge the employer from any further liability for workers' compensation disability benefits, including medical benefits as detailed in paragraph seven (7).

11. The law firm of Dewey, Cheatham & Howe, LLP, has represented and counseled the claimant since December 2, 2010 with regard to this case. Claimant's counsel has continually reviewed this file from a legal and medical standpoint and has engaged in negotiations with the employer in an effort to arrive at the aforementioned settlement. Accordingly, the law firm of Dewey, Cheatham & Howe, LLP, is requesting approval of an attorney's fee in the amount of $1,900.00. The amount of the fee has been discussed with the claimant, he understands that this fee is to be deducted from the settlement proceeds referred to in Paragraph 6 above, and agrees that said fee is fair and reasonable.

The Associate Director, Office of Workers' Compensation, pursuant to the authority vested in him in Section 32-1508(8) of the District of Columbia Workers' Compensation Act of 1979 and acting as the designee of the Mayor of the District of Columbia, finds that it is in the

best interest of the claimant, discharging the liability of the employer and insurance carrier for such compensation consistent with the terms of the agreed settlement

Date

Flash Gordon
1 CLAIMANT

Date

Claimant's Counsel, Esq.
Dewey, Cheatham & Howe, LLP
2011 XYZ Street, NW
Washington, D.C. 20036
ATTORNEY FOR CLAIMANT

Date

Employer's Counsel, Esquire
FRANKLIN & PROKOPIK
Two North Charles Street, Suite 600
Baltimore, MD 21201
COUNSEL FOR EMPLOYER/CARRIER

Exhibit 13

DISTRICT OF COLUMBIA DEPARTMENT OF EMPLOYMENT SERVICES
Administrative Hearings Divisions
Office of Hearings and Adjudication
4058 Minnesota Avenue, N.E., 4th Floor, Washington, DC 20019
(202) 671-2233

APPLICATION FOR FORMAL HEARING

OWC File No. 690833

Name of party on whose behalf this Application is submitted: _____

IF THE PARTY APPLYING FOR A FORMAL HEARING IS REPRESENTED, A COPY OF THE REPRESENTATIVE'S AUTHORIZATION MUST BE ATTACHED TO THIS APPLICATION.

Name, address, and phone number of the employee: _____.

Name, address, and phone number of the employee's representative: _____.

Name, address, and phone number of employer: _____.

Name, address, and phone number of carrier: _____.

Name, address, and phone number of the employer/carrier's representative: _____.

Have the parties attended an informal conference held by the Office of Workers' Compensation?

( ) yes ( ) no. Has the employee filed a claim (Employee's Claim Application, Form No. 7A DCWC)? ( ) yes ( ) no. If yes, attach a copy of the employee's claim. HEARINGS WILL NOT BE PLACED ON THE DOCKET UNTIL A CLAIM (EMPLOYEE'S CLAIM APPLICATION, FORM 7A DCWC) HAS BEEN FILED.

State the facts of the claim: _____.

State the issues you will present for resolution at the hearing: _____ .

Does the employee have other claims pending with the OWC? ( ) yes ( ) no. If yes, state OWC No(s).:

Type or Print the name of the person submitting this Application: _____.

Signature: _____
Date: _____

I HEREBY CERTIFY that a duplicate of the Application for Formal Hearing was (check applicable method) ( ) duly served in person, or () sent by certified mail on this _____ day of August, 2012 to: (NAME), Associate Director, Office of Workers' Compensation, 4058 Minnesota Avenue, N.E., 4th Floor, Washington, DC 20019 and (NAME), Esquire, Attorney for Claimant.

_____
Defense Attorney, Esquire

Exhibit 14

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 1 year after your injury, or within 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 web site. The web site 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 Worker's Compensation. The medical treatment includes medical services, supplies, prosthetic devices, and prescriptions. The 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 $66^{2/3}$% 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 14^{th} 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, temporary partial or permanent partial or permanent partial disability benefits will be limited to 500 weeks. Within 60 days of the expiration date, the claimant may petition for an extension of benefits up to 167 weeks beyond the 500-week cap.

- 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

Exhibit 15

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

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

FRANKLIN & PROKOPIK
A PROFESSIONAL CORPORATION
ATTORNEYS AT LAW

The B & O Building
2 N. Charles Street, Suite 600
Baltimore, Maryland 21201
410.752.8700
410.752.6868 Fax

8603 Commerce Drive
Suite 7A
Easton, Maryland 21601
410.820.0600
410.820.0300 Fax

1101 Opal Court
Hub Plaza, Suite 210
Hagerstown, Maryland 21740
301.745.3900
301.766.4676 Fax

2325 Dulles Corner Boulevard
Suite 1150
Herndon, Virginia 20171
703.793.1800
703.793.0298 Fax

100 S. Queen Street
Suite 200
Martinsburg, West Virginia 25401
304.596.2277
304.596.2111 Fax

500 Creek View Road
Suite 502
Newark, DE 19711
302.594.9780
302.594.9785 Fax
Please note our new location

5516 Falmouth Street
Suite 203
Richmond, VA 23230
804.932.1996
804.403.6007 Fax