One good reason to think twice about workers' compensation fraud

EMPLOYERS® actively investigates suspected workers' compensation fraud and reports such cases to law enforcement authorities.

fraud costs

Workers' compensation fraud costs $7.2 billion annually.[1]

Filing a fraudulent workers' compensation claim could lead to serious civil or criminal consequences, such as fines, incarceration and/or restitution.

If you suspect workers' compensation fraud, please contact EMPLOYERS' Fraud Investigations Department. Call the Fraud Hotline at 1-800-750-3939 or e-mail fraudfighters@employers.com.

EMPLOYERS®

America's small business insurance specialist®

1 Source: http://www.propertycasualty360.com/2015/07/23/3-keys-to-a-successful-workers-compensation-fraud

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REV 09/2015

Una buena razón para pensarlo dos veces antes de cometer fraude en una demanda de indemnización laboral

EMPLOYERS® investiga de manera activa casos sospechosos de cometer fraude en una demanda de indemnización laboral y reporta dichos casos a las autoridades policiales.

costos del fraude

Fraude en demandas de indemnización laboral cuesta $7.2 mil millones al año.[1]

Presentar una demanda de indemnización laboral fraudulenta puede acarrear graves consecuencias civiles o penales, tales como multas, cárcel y/o indemnizaciones.

Si sospecha que existe fraude en una demanda de indemnización laboral, póngase en contacto con el Departamento de Investigación de Fraude de EMPLOYERS. Llame a la línea directa de fraude al 1-800-750-3939 o escriba al correo electrónico fraudfighters@employers.com.

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1 Fuente: http://www.propertycasualty360.com/2015/07/23/3-keys-to-a-successful-workers-compensation-fraud

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1 Fuente: http://www.propertycasualty360.com/2015/07/23/3-keys-to-a-successful-workers-compensation-fraud

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OPTUM®

PO Box 152539
Tampa, FL 33684-2539

EMPLOYERS®
America's small business insurance specialist®

MAKING IT EASY TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured person:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacy will fill the prescription at no cost to you.

If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Employer:

Immediately upon receiving notice of injury, fill in the information below and give this form to the employee.

Finding a network pharmacy

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

EMPLOYERS®
America's small business insurance specialist®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Employers
CARRIER/TPA — EMPLOYER

INJURED PERSON NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER — DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	EMPLFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

tmesys®

IMP14-2013-84

OPTUM®

PO Box 152539
Tampa, FL 33684-2539

EMPLOYERS®
America's small business insurance specialist®

HACEMOS MÁS SENCILLO QUE SE LE ABASTEZCA LAS RECETAS DE SU PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Persona lesionada:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información que aparece a continuación y entregue este formulario al empleado.

Cómo encontrar una farmacia de la red

La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para ubicar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta? ¿Necesita ayuda?

1-866-599-5426

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WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Employers
PORTADORA — EMPLEADOR

NOMBRE DEL PERSONA LESIONADA

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE LA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	EMPLFF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

tmesys®

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Basic Accident Report

Date of Report:_____ Report Completed By:_____

Last Name of Injured Person:	First Name:	Job Title:
Date of Accident:	Time of Accident:	Location of Accident:
Supervisor's Name & Job Title:	Name of Witnesses:	
Full Description of Injuries:		
Description of accident/incident or employee's account, including sequence of events preceding the accident:		
Basic cause and contributory causes. Explain fully unsafe act, unsafe condition, personal factor, other:		
Recommended Corrective Measures:		Action By:
Names of Inspection Team Participants:		
Management Review By:	Date to be Completed By:	

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America's small business insurance specialist®

Informe Básico de Accidentes

Fecha Del Informe:_____Informe Completado Por:_____

Apellido De La Persona Lesionada:	Primer Nombre:	Puesto De Trabajo:
Fecha Del Accidente:	Hora Del Accidente:	Lugar Del Accidente:
Nombre Del Supervisor Y Cargo:	Nombre De Los Testigos:	
Descripción Completa De Las Lesiones:		
Descripción del accidente / incidente o versión del empleado, incluyendo la secuencia de eventos que preceden al accidente:		
Causas básicas y causas contributivas. Explique el tipo de situación ya sea si fue una situación insegura, condición insegura, factor personal, otros:		
Medidas Correctivas Recomendadas:		Acciones Tomadas Por:
Nombres De Los Participantes Del Equipo De Inspección:		
Revisión Por Parte De La Gerencia:	Fecha Límite De Entrega:	

District of Columbia Government
Office of Worker's Compensation
P.O. Box 56098
Washington, DC 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.

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 his/her's employees, but no later than ten 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 of disability began? _____ am/pm? Was the injured paid in full for this day? _____
Was the injured given Form No. 7 DCWC? _____ Foreman_____
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

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

GOBIERNO DEL DISTRITO DE COLUMBIA
DEPARTAMENTO DE SERVICIOS DE EMPLEO
OFICINA DE COMPENSACIÓN PARA TRABAJADORES
PO BOX 56098
WASHINGTON, DC 20011
(202) 671-1000
(202) 671-1929 (fax)

Advertencia: Es un crimen proporcionar información falsa o engañosa a un asegurador para defraudarlo o defraudar a cualquier otra persona. Las multas incluyen el encarcelamiento o multas. Asimismo, un asegurador puede denegar beneficios de seguro si el solicitante proporcionó información falsa relacionada materialmente cn una reclamación.

AVISO DE CONFORMIDAD

A LOS EMPLEADOS

1. **La ley le exige que reporte cuanto antes a su empleador y a la Oficina de Compensación para Trabajadores una lesión o enfermedad ocupacional, incluso aunque considere que es pequeña. Para ello debe utilizarse el Formulario DCWC 7, Aviso de Lesión Accidental o Enfermedad Ocupacional del Empleado, que puede obtener se del empleador o de la Oficina de Compensación para Trabajadores. Después de haberlo completado y firmado, debería enviarlo por correo a la Oficina de Compensación para Trabajadores, a la dirección que figura arriba, y a su empleador.**

2. **Tiene derecho, si se solicita, a los servicios de un médico u hospital de su elección y a la recuperación de salarios perdidos. Llame al (202) 671-1000 para obtener información al respecto.**

3. **No puede iniciar pleito contra su empleador como resultado de una lesión o enfermedad relacionada con el trabajo. La ley de Compensación para Trabajadores es su único remedio.**

4. **Para mantener su derecho a beneficios en virtud de la Ley de Compensación para Trabajadores, debe presentar una reclamación por escrito en el Formulario DCWC 7a, Solicitud de Reclamación del Empleado, dentro de un (1) año después de la fecha de su lesión, o dentro de un (1) año del último pago de beneficios.**

5. **Si desea información referente a sus derechos y obligaciones estipulados por ley, puede llamar primero a su empleador. Si necesita más información, puede llamar a la Oficina de Compensación para Trabajadores, al (202) 671-1000.**

6. **La ley le da el derecho a obtener representación si lo desea.**

A LOS EMPLEADORES

1. **Tiene la obligación de tener cobertura de seguro de Compensación para Trabajadores si tiene 1 o más empleados.**

2. **Tiene la obligación de mostrar este póster en todos los lugares de trabajo para beneficio de sus empleados.**

3. **Debe presentar un Formulario DCWC 8, Reporte Inicial del Empleador de Lesión o Enfermedad Ocupacional, a la Oficina de Compensación para Trabajadores, enviando una copia del mismo a la oficina de reclamaciones más cercana de su compañía de seguros, para todas las lesiones o enfermedades ocupacionales, cuanto antes, a más tardar 10 días después de la fecha en que tuvo conocimiento de las mismas.**

4. **Su empleado debe presentar el Formulario DCWC 7, Aviso de Lesión Accidental o Enfermedad Ocupacional del Empleado. Por favor, proporcione a su empleado un Formulario DCWC 7 e indíquele que lo complete y se lo devuelva a usted y a la Oficina de Compensación para Trabajadores. Una vez que haya recibido aviso del empelado, tiene que enviarle un aviso de sus derechos y obligaciones por correo certificado, solicitando acuse de recibo.**

5. **Debe reportar a la Oficina de Compensación para Trabajadores, y a su asegurador, toda discapacidad superior a 3 días que no haya sido reportada anteriormente, cuanto antes, a más tardar 10 días después de la fecha en que tuvo conocimiento de la misma.**

6. **Debe proporcionar o hacer que se proporcione, servicios médicos y hospitalarios razonables, otra atención de remedio o rehabilitación vocacional, y diversos tipos de compensación por discapacidad a un empleado lesionado o discapacitado.**

7. **Debe obtener del asegurador identificado abajo, un suministro de todos los Formularios de Compensación para Trabajadores requeridos, o puede descargar los formularios y el aviso mencionado arriba en nuestro sitio web: http://www.does.dc.gov**

AVISO: La infracción de las diversas disposiciones de la ley de Compensación para Trabajadores conllevará penalidades civiles.

Por la presente, el empleador suscrito da aviso de conformidad con todas las disposiciones de la Ley de Compensación para Trabajadores y sus Reglas Administrativas.

NOMBRE DE LA COMPAÑÍA ASEGURADORA

NOMBRE DEL EMPLEADOR

POR_____

_____

Número de identificación del empleador
(Si se desconoce, el empleador debe solicitarlo al IRS)

ESTE AVISO DEBE PUBLICARSE CONSPICUAMENTE EN LOS LUGARES DE OPERACIÓN DEL EMPLEADOR

FORMULARIO 1 DCWC **Revisado en junio de 2002**

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

(202) 671-1000

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 BOTH COPIES OF THIS SCHEDULE NO LATER THAN EMPLOYEE'S TENTH (10TH) DAY OF LOSS OF WAGES.

THIS WAGE SCHEDULE IS FOR 13 WEEKS PRIOR TO DATE OF INJURY, OR 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 the employer, and gratuities declared for tax purposes.)

Date of Injury: _____ No. of dependents claimed last year for Federal Tax: _____

Description of Injury: _____

Date of Hire: _____ Hourly Wages: _____ Average Weekly Earnings: _____

	1	2	3
WEEK ENDING	GROSS EARNINGS	OTHER ADVANTAGES (see wages definition)	TOTAL Columns 1 & 2
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			

IF WAGES FIXED BY WEEK, MONTH OR YEAR, STATE AMOUNT: _____ per _____

_____ _____

Employer's Signature Title

Office Approval and Date

922173

FORM NO. 10 DCWC

ORIGINAL - OWC OFFICE

OPTUM®

PO Box 152539
Tampa, FL 33684-2539

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America's small business insurance specialist®

MAKING IT EASY TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured person:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacy will fill the prescription at no cost to you.

If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Employer:

Immediately upon receiving notice of injury, fill in the information below and give this form to the employee.

Finding a network pharmacy

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

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America's small business insurance specialist®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Employers
CARRIER/TPA — EMPLOYER

INJURED PERSON NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER — DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	EMPLFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

tmesys®

IMP14-2013-84

OPTUM®

PO Box 152539
Tampa, FL 33684-2539

EMPLOYERS®
America's small business insurance specialist®

HACEMOS MÁS SENCILLO QUE SE LE ABASTEZCA LAS RECETAS DE SU PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Persona lesionada:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información que aparece a continuación y entregue este formulario al empleado.

Cómo encontrar una farmacia de la red

La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para ubicar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta? ¿Necesita ayuda?

1-866-599-5426

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WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Employers
PORTADORA — EMPLEADOR

NOMBRE DEL PERSONA LESIONADA

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE LA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	EMPLFF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

tmesys®

EMPLOYERS®

America's small business insurance specialist®

Basic Accident Report

Date of Report:_____ Report Completed By:_____

Last Name of Injured Person:	First Name:	Job Title:
Date of Accident:	Time of Accident:	Location of Accident:
Supervisor's Name & Job Title:	Name of Witnesses:	
Full Description of Injuries:		
Description of accident/incident or employee's account, including sequence of events preceding the accident:		
Basic cause and contributory causes. Explain fully unsafe act, unsafe condition, personal factor, other:		
Recommended Corrective Measures:		Action By:
Names of Inspection Team Participants:		
Management Review By:	Date to be Completed By:	

EMPLOYERS®

America's small business insurance specialist®

Informe Básico de Accidentes

Fecha Del Informe:_____Informe Completado Por:_____

Apellido De La Persona Lesionada:	Primer Nombre:	Puesto De Trabajo:
Fecha Del Accidente:	Hora Del Accidente:	Lugar Del Accidente:
Nombre Del Supervisor Y Cargo:	Nombre De Los Testigos:	
Descripción Completa De Las Lesiones:		
Descripción del accidente / incidente o versión del empleado, incluyendo la secuencia de eventos que preceden al accidente:		
Causas básicas y causas contributivas. Explique el tipo de situación ya sea si fue una situación insegura, condición insegura, factor personal, otros:		
Medidas Correctivas Recomendadas:		Acciones Tomadas Por:
Nombres De Los Participantes Del Equipo De Inspección:		
Revisión Por Parte De La Gerencia:	Fecha Límite De Entrega:	

District of Columbia Government
Office of Worker's Compensation
P.O. Box 56098
Washington, DC 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.

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 his/her's employees, but no later than ten 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 of disability began? _____ am/pm? Was the injured paid in full for this day? _____
Was the injured given Form No. 7 DCWC? _____ Foreman_____
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

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

GOBIERNO DEL DISTRITO DE COLUMBIA
DEPARTAMENTO DE SERVICIOS DE EMPLEO
OFICINA DE COMPENSACIÓN PARA TRABAJADORES
PO BOX 56098
WASHINGTON, DC 20011
(202) 671-1000
(202) 671-1929 (fax)

Advertencia: Es un crimen proporcionar información falsa o engañosa a un asegurador para defraudarlo o defraudar a cualquier otra persona. Las multas incluyen el encarcelamiento o multas. Asimismo, un asegurador puede denegar beneficios de seguro si el solicitante proporcionó información falsa relacionada materialmente cn una reclamación.

AVISO DE CONFORMIDAD

A LOS EMPLEADOS

1. **La ley le exige que reporte cuanto antes a su empleador y a la Oficina de Compensación para Trabajadores una lesión o enfermedad ocupacional, incluso aunque considere que es pequeña. Para ello debe utilizarse el Formulario DCWC 7, Aviso de Lesión Accidental o Enfermedad Ocupacional del Empleado, que puede obtener se del empleador o de la Oficina de Compensación para Trabajadores. Después de haberlo completado y firmado, debería enviarlo por correo a la Oficina de Compensación para Trabajadores, a la dirección que figura arriba, y a su empleador.**

2. **Tiene derecho, si se solicita, a los servicios de un médico u hospital de su elección y a la recuperación de salarios perdidos. Llame al (202) 671-1000 para obtener información al respecto.**

3. **No puede iniciar pleito contra su empleador como resultado de una lesión o enfermedad relacionada con el trabajo. La ley de Compensación para Trabajadores es su único remedio.**

4. **Para mantener su derecho a beneficios en virtud de la Ley de Compensación para Trabajadores, debe presentar una reclamación por escrito en el Formulario DCWC 7a, Solicitud de Reclamación del Empleado, dentro de un (1) año después de la fecha de su lesión, o dentro de un (1) año del último pago de beneficios.**

5. **Si desea información referente a sus derechos y obligaciones estipulados por ley, puede llamar primero a su empleador. Si necesita más información, puede llamar a la Oficina de Compensación para Trabajadores, al (202) 671-1000.**

6. **La ley le da el derecho a obtener representación si lo desea.**

A LOS EMPLEADORES

1. **Tiene la obligación de tener cobertura de seguro de Compensación para Trabajadores si tiene 1 o más empleados.**

2. **Tiene la obligación de mostrar este póster en todos los lugares de trabajo para beneficio de sus empleados.**

3. **Debe presentar un Formulario DCWC 8, Reporte Inicial del Empleador de Lesión o Enfermedad Ocupacional, a la Oficina de Compensación para Trabajadores, enviando una copia del mismo a la oficina de reclamaciones más cercana de su compañía de seguros, para todas las lesiones o enfermedades ocupacionales, cuanto antes, a más tardar 10 días después de la fecha en que tuvo conocimiento de las mismas.**

4. **Su empleado debe presentar el Formulario DCWC 7, Aviso de Lesión Accidental o Enfermedad Ocupacional del Empleado. Por favor, proporcione a su empleado un Formulario DCWC 7 e indíquele que lo complete y se lo devuelva a usted y a la Oficina de Compensación para Trabajadores. Una vez que haya recibido aviso del empelado, tiene que enviarle un aviso de sus derechos y obligaciones por correo certificado, solicitando acuse de recibo.**

5. **Debe reportar a la Oficina de Compensación para Trabajadores, y a su asegurador, toda discapacidad superior a 3 días que no haya sido reportada anteriormente, cuanto antes, a más tardar 10 días después de la fecha en que tuvo conocimiento de la misma.**

6. **Debe proporcionar o hacer que se proporcione, servicios médicos y hospitalarios razonables, otra atención de remedio o rehabilitación vocacional, y diversos tipos de compensación por discapacidad a un empleado lesionado o discapacitado.**

7. **Debe obtener del asegurador identificado abajo, un suministro de todos los Formularios de Compensación para Trabajadores requeridos, o puede descargar los formularios y el aviso mencionado arriba en nuestro sitio web: http://www.does.dc.gov**

AVISO: La infracción de las diversas disposiciones de la ley de Compensación para Trabajadores conllevará penalidades civiles.

Por la presente, el empleador suscrito da aviso de conformidad con todas las disposiciones de la Ley de Compensación para Trabajadores y sus Reglas Administrativas.

NOMBRE DE LA COMPAÑÍA ASEGURADORA

NOMBRE DEL EMPLEADOR

POR_____

_____

Número de identificación del empleador
(Si se desconoce, el empleador debe solicitarlo al IRS)

ESTE AVISO DEBE PUBLICARSE CONSPICUAMENTE EN LOS LUGARES DE OPERACIÓN DEL EMPLEADOR

FORMULARIO 1 DCWC **Revisado en junio de 2002**

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

(202) 671-1000

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 BOTH COPIES OF THIS SCHEDULE NO LATER THAN EMPLOYEE'S TENTH (10TH) DAY OF LOSS OF WAGES.

THIS WAGE SCHEDULE IS FOR 13 WEEKS PRIOR TO DATE OF INJURY, OR 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 the employer, and gratuities declared for tax purposes.)

Date of Injury: _____ No. of dependents claimed last year for Federal Tax: _____

Description of Injury: _____

Date of Hire: _____ Hourly Wages: _____ Average Weekly Earnings: _____

	1	2	3
WEEK ENDING	GROSS EARNINGS	OTHER ADVANTAGES (see wages definition)	TOTAL Columns 1 & 2
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			

IF WAGES FIXED BY WEEK, MONTH OR YEAR, STATE AMOUNT: _____ per _____

_____ _____

Employer's Signature Title

Office Approval and Date

922173

FORM NO. 10 DCWC

ORIGINAL - OWC OFFICE