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