



GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT



Jed Ross
Chief Risk Officer

Public Sector Workers'
Compensation Program

FORM 12 - EMPLOYEE CLAIM FOR PERMANENT DISABILITY COMPENSATION

Use this form to file a claim for a schedule award for permanent disability compensation pursuant to D.C. Code § 1-623.07 with the District of Columbia Public Sector Workers' Compensation Program (PSWCP).

READ INSTRUCTIONS HERE AND ON THE REVERSE SIDE

You **MUST** complete Sections I and II of this form in their entirety. Please submit with this form any necessary attachments. Section III must be completed by a qualified physician with specific training and experience in the use of the most recent edition of the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment at the time of submission and shall be accompanied by any medical records, report, or evidence that support any rating.

SECTION I. To be completed by Claimant or Representative.

Claimant's Name: _____

Claimant's Full Address (with unit number, zip code):

Claimant's Telephone: _____

Claimant's E-mail: _____

Claim Number: _____

Date of Birth: _____

Social Security No.: _____

Temporary Indemnity

Benefits Started: _____

Representative (if any): _____

Rep.'s Full Address (with unit number, zip code):

Rep.'s Telephone: _____

Rep.'s Fax: _____

Rep.'s E-mail _____

Date of Injury: _____

Employing Agency: _____

Temporary Indemnity

Benefits Ended: _____

SECTION II. To be completed by Claimant. Circle YES or NO in response to ALL questions in this section.

- | | | |
|--|------------------------------|-----------------------------|
| 1. Did you receive temporary disability indemnity compensation for this injury? | ☐ YES | ☐ NO |
| 2. Has a qualified physician documented that you have reached maximum medical improvement for your disability? | ☐ YES | ☐ NO |
| 3. Did you suffer the loss of both hands, both arms, both feet, or both legs, or sight in both eyes as a result of your work injury? | ☐ YES | ☐ NO |
| 4. Have you ever filed a claim for or received permanent disability in the past? | ☐ YES | ☐ NO |
| 5. Has 181 days or more past since you last received any temporary disability indemnity compensation payment? (If yes, explain good cause for the delay in submitting Form 12 and attach proof.) | ☐ YES | ☐ NO |

CERTIFICATION: I have read this form and I swear or affirm under penalty of perjury under the laws of the District of Columbia that the contents are true and accurate to the best of my knowledge.

Print Name

Signature

Date

➔ ➔ TURN OVER TO CONTINUE ➔ ➔

Claimant Name: _____ Claim No.: _____

SECTION III. To be completed by Physician. *Physician's medical report in support of the following opinions must be attached and submitted with this request.*

A. Doctor's Information:

Name: _____ Practice Name: _____
Office Address: Office Phone No.: _____
Office Fax No.: _____

B. Diagnosis or Nature of Disease or Injury

	Enter ICD 10 Code	ICD10 Description
(1)	_____	_____
(2)	_____	_____
(3)	_____	_____
(4)	_____	_____

C. Maximum Medical Improvement

Has the patient reached Maximum Medical Improvement (MMI)? ☐ YES ☐ NO
If yes, please provide date patient reached MMI: _____

D. Permanent Impairment

Is there a permanent impairment? ☐ YES ☐ NO
Schedule loss of use of member of facial disfigurement. (Check and identify impairment rating according to the latest AMA Guidelines and attach separate sheet for additional body parts).

☐ Schedule Loss ☐ Facial Disfigurement

Body Part: _____	Impairment %: _____
Body Part: _____	Impairment %: _____
Body Part: _____	Impairment %: _____

Describe findings and relevant diagnostic test results:

(attach medical records, evidence or report in support of findings)

E. Health Care Provider Certification: Signed under penalty of perjury.

Name	Signature	Specialty	Date
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Claimant **MUST** file this claim for permanent disability by mail or in person with the PSWCP at the District of Columbia Office of Risk Management between the hours of 8:30 a.m. and 5:00 p.m. at:

Office of Risk Management
One Judiciary Square
441 Fourth Street, N.W., Suite 800 South
Washington, DC 20001-2714
Phone: (202) 442-HELP (4357)