GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers' Compensation Program

Form 13 - REQUEST FOR WAIVER OR CHALLENGE OF PRELIMINARY DECISION ON OVERPAYMENT

READ INSTRUCTIONS HERE AND ON THE REVERSE SIDE

Use this form to challenge or request for waiver of the Public Sector Workers' Compensation Program's (PSWCP's) Preliminary Determination of Overpayment ("Preliminary Determination") pursuant to D.C. Code § 1-623.29 and 7 D.C.M.R. 3333.

SUBMISSION DEADLINE: Your request or waiver of or challenge to the Preliminary Determination must be received by the Office of Risk Management (ORM) within **thirty (30)** calendar days, from the date that the PSWCP issued the Preliminary Determination. If the calendar-day filing deadline falls on a Saturday, Sunday, or a legal holiday, the deadline is extended to the next business day ORM is open.

Please submit with this form a copy of the Preliminary Determination and any necessary attachments. This request, excluding supporting documentation, shall not exceed 10 pages.

CLAIMANT INFORMATION

Claimant's Name: _____

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

Claimant's Telephone: _____

Claimant's E-mail: _____

Claim Number: _____

Employing Agency: _____

Representative (if any): _____

Rep.'s Telephone: _____

Rep.'s Fax: _____

Rep.'s E-mail _____

Date of Injury: _____

Date of Notice of Preliminary Determination: _____

REASON – CHECK ALL THAT APPLY

☐ **I request a waiver of the adjustment or recovery because it will result in severe financial hardship.** (If you check this box, please complete and attach Form 13F – Financial Statement Form and attach records, proof, or evidence in support of your position).

☐ **I challenge the PSWCP's preliminary finding of fault against me.** (Please explain your position below. Use additional paper if necessary. Attach records, proof, or evidence in support of your position.)

➔ ➔ **TURN OVER TO CONTINUE** ➔ ➔

☐ I challenge the fact or amount of the overpayment. (Please explain your position below. Use additional paper if necessary. Attach records, proof, or evidence in support of your position.)

I have read this Form and I swear or affirm that the contents are true and accurate to the best of my knowledge.

Print Name Signature Date

WHERE TO FILE: Return this form to **ORM/PSWCP by mail, in person, e-mail, or fax**. You may return the form in person, weekdays between 8:30 a.m. and 5:00 p.m. You will need photo identification to enter the building:

Office of Risk Management
One Judiciary Square
441 Fourth Street, NW, Suite 800 South
Washington, D.C. 20001
Phone: (202) 442-HELP (4357)
E-mail: wcsecure@dc.gov
Fax: (202) 535-1130
Please visit http://www.orm.dc.gov for more information.

This form must be received by ORM no later than the 30th day after the Date of the Notice of Preliminary Determination of Overpayment. If this form is forwarded by mail, there is no guarantee that it will be received by ORM within 30 days.