



GOVERNMENT OF THE DISTRICT OF COLUMBIA

OFFICE OF RISK MANAGEMENT



Jed Ross
Chief Risk Officer

Public Sector Workers'
Compensation Program

FORM 8 – EMPLOYEE AFFIDAVIT OF REPORT OF EARNINGS

NOTICE TO EMPLOYEE: DISTRICT LAW REQUIRES ALL PERSONS RECEIVING OR CLAIMING PSWCP BENEFITS TO REPORT ALL EARNINGS TO THE OFFICE OF RISK MANAGEMENT (ORM). PLEASE COMPLETE THIS REPORT AND RETURN TO ORM WITHIN THIRTY (30) DAYS AFTER THE DATE OF YOUR RECEIPT. Failure or refusal of employee to complete sections I - VII, sign and return this report **within thirty (30) days** after receipt of the request, or knowingly omitting or understating earnings, shall cause claimant's PSWCP benefits to be forfeited with no further written notice. Failure to complete this report for more than 90 days may result in termination of compensation and civil or criminal liability. **PLEASE PRINT OR TYPE. (USE ADDITIONAL PAPER AND ATTACH EARNINGS DOCUMENTATION IF NECESSARY)**

I. Identification of Party (To be completed by ORM representative)				
Employee's Name		Employee's Address		Claim Number
II. Time Period to be Reported		From January 1,		To December 31,
III. During the time period in Section II, have you received income from any source other than workers' compensation? ☐ Yes ☐ No				
*** Earnings include any cash, wages, salary, commissions, bonuses, and the cash value of all payments and benefits received in any form. ***				
IV During the time period in Section II, have you received earnings from a person, firm or company? ☐ Yes (If yes, complete information below) ☐ No				
Employer Name and Position Held		Address		Period Worked
				Total Gross Earnings
V. During the time period in Section II, were you Self-Employed? ☐ Yes (If yes, complete information below) ☐ No				
Dates Self-Employed		Gross Wages, Income, or Benefits Received		Description of business or work performed
From	To			
From	To			
VI. During the time period in Section II, did you receive Social Security Benefits? ☐ Yes (If yes, complete information below) ☐ No				
Total	Benefit Type		Amount Paid for Your Injury	Amount Paid for Your Dependents
VII. Other Benefits (Unemployment, Workers' Compensation from elsewhere, Retirement, Severance, or any other Government Benefits)				
Do you receive any other benefits?		Period Benefits Received		Total Amount
☐ Yes ☐ No				
Source of Wages, Income, or Benefits		From	To	
VIII. During the time period in Section II, did you perform any remunerable or volunteer activity? ☐ Yes (If yes, complete below) ☐ No				
A remunerable activity is any service performed for which you have derived any benefit other than pay.				
Activity	Organization	Address		Period activity performed
				From To
IX. Certification. It is a crime to provide false or misleading information to the District of Columbia Government, or to any department or agency thereof, regarding any claim upon or against the District of Columbia, or any department or agency thereof, knowing such claim to be false, fictitious, or fraudulent. Such an act is punishable by civil and criminal penalties, including imprisonment, fines, and costs of up to \$100,000 or more. In addition, the District may deny a claim if false information materially related to the claim was provided by the applicant. I HAVE REVIEWED, UNDERSTAND, AND ACKNOWLEDGE THE ABOVE. I SWEAR (OR AFFIRM) UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE DISTRICT OF COLUMBIA THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.				
EMPLOYEE'S SIGNATURE _____			DATE _____	
X. Notarized				
Signed and sworn to (or affirmed) before me on _____ (date) by _____ (name of person making statement).		Signature of Notarial Officer _____ My Commission Expires: _____ (Seal)		