GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers' Compensation Program

FORM 7 – EMPLOYEE PSWCP FILE REQUEST

Use this form to obtain a copy of your Public Sector Workers' Compensation File.

CLAIMANT INFORMATION

Name: _____ **Telephone:** _____

Claim Number: _____ **Claims Examiner:** _____

Claimants are entitled to one (1) copy of his or her claim file per year. Additional electronic or hard copies of documents in the file made in the same year shall be provided at the cost of five cents per page.

PLEASE MARK YOUR REQUEST BELOW:

☐ View my PSWCP file

☐ Obtain a copy of my PSWCP file.

Please select format:

- ☐ Electronic Copy (provided on a CD or thumb drive)
- ☐ Hard Copy

Please select documents requested:

- ☐ Entire File;
- ☐ Records from the period _____ to _____; or
- ☐ Pay History

I verify that the above information is correct and that I am the employee requesting the file. I understand that I will only be allowed to review the file at the Public Sector Workers' Compensation Program (PSWCP) office in the presence of a PSWCP staff member.

Print Name	Signature	Date

Claimant **MUST** file this claim for disability by mail, e-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) 727-8600** **Email: wcsecure@dc.gov**