**DISTRICT OF COLUMBIA GOVERNMENT** **OFFICE OF RISK MANAGEMENT**

# PUBLIC SECTOR WORKERS’ COMPENSATION PROGRAM (PSWCP) EMPLOYEE REPORT OF EARNINGS

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| --- | --- |
| CORVEL CMS RECEIVED DATE | ORM RECEIVED DATE |
|  |  |

Failure or refusal of employee to complete, sign and return this report within thirty (30) days after receipt of the request, or knowingly omitting or understating earnings, may cause payment of PSWCP benefits to stop until such time as the completed form is furnished to the requesting party.

PLEASE PRINT OR TYPE; IF ADDITIONAL SPACE IS NECESSARY TO ANSWER QUESTIONS, PLEASE ATTACH AS AN ADDENDUM TO THIS FORM.

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| **I. IDENTIFICATION OF PARTIES (To be completed by ORM representative)** |
| EMPLOYEE’S SOCIAL SECURITY NUMBER | EMPLOYEE’S NAME (First, Middle, Last) | DATE OF INJURY (Month-Day-Year) |
| EMPLOYEE’S ADDRESS | EMPLOYER’S NAME & ADDRESS | ORM NAME & ADDRESS |
| **II. NOTICE TO EMPLOYEE** |
| DISTRICT LAW REQUIRES ALL PERSONS RECEIVING OR CLAIMING PSWCP BENEFITS TO REPORT ALL EARNINGS\* TO THE OFFICE OF RISK MANAGEMENT. PLEASE COMPLETE THIS REPORT AND RETURN TO ORM WITHIN THIRTY (30) DAYS AFTER THE DATE OF YOUR RECEIPT. |
| TIME PERIOD TO BE REPORTED**FROM** | **TO** | HAVE YOU RECEIVED INCOME FROM ANY SOURCE OTHER THAN WORKERS’ COMPENSATION?* YES (IF YES, COMPLETE FORM, SIGN, DATE & RETURN)
* NO (IF NO, SIGN, DATE AND RETURN)
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| **IF NECESSARY, ATTACH ADDITIONAL EARNINGS DOCUMENTATION** |
| **III. HAVE YOU RECEIVED EARNINGS FROM ANY PERSON, FIRM OR COMPANY DURING THE TIME PERIOD IN SECTION II?** | □YES (IF YES, COMPLETE INFORMATION BELOW)* NO
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| EMPLOYER NAME AND POSITION HELD | ADDRESS | PERIOD WORKED | TOTAL GROSS EARNINGS |
| **FROM** | **TO** |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **IV. DURING THE TIME PERIOD IN SECTION II, HAVE YOU BEEN SELF EMPLOYED?**□YES □ NO | BRIEFLY DESCRIBE NATURE OF BUSINESS OR SERVICE |
| DATES SELF-EMPLOYED | WAGES, INCOME, OR BENEFITS RECEIVED | DATES SELF-EMPLOYED | WAGES, INCOME OR BENEFITS RECEIVED |
| FROM | TO |  | FROM | TO |  |
| **V. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED ANY SOCIAL SECURITY BENEFITS?*** YES (IF YES, STATE AMOUNTS) □ NO
 |
| TOTAL MONTHLY SOCIAL SECURITY INCOME | AMOUNT PAID FOR YOUR INJURY | AMOUNT PAID FOR YOUR DEPENDENTS |
| **VI. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED WAGES, INCOME, OR BENEFITS FROM ANY OTHER SOURCE, INCLUDING BUT NOT LIMITED TO, i.e. Unemployment Compensation Benefits, Workers’ Compensation Benefits from another insurer, OR ANY OTHER GOVERNMENT BENEFITS PROGRAM. Attach additional documentation if necessary.*** YES (IF YES, STATE AMOUNTS) □ NO
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| **PERIOD BENEFITS RECEIVED** | TOTAL AMOUNT |
| SOURCE OF WAGES, INCOME OR BENEFITS | FROM | TO |
| 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 subject to imprisonment of not more than one year and a fine of not more than $100,000 for each violation.I HAVE REVIEWED, UNDERSTAND, AND ACKNOWLEDGE THE ABOVE. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. EMPLOYEE’S SIGNATURE DATE  |
| **VII. RETURN TO (To be completed by requesting party):** |
| REQUESTING PARTY’S NAME | REQUESTING PARTY’S SIGNATURE | REQUESTING PARTY’S ADDRESS &TELEPHONE |
| TITLE | DATE: (Month-Day-Year) |

# \*Earnings include any cash, wages, salary, commissions, bonuses, and the cash value of all payments and benefits received in any form other than cash, that were earned from self-employment or from any other employment engaged in after your workers’ compensation injury.