GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers' Compensation Program

FORM 1 – EMPLOYEE'S NOTICE OF INJURY & CLAIM FOR CONTINUATION OF PAY (COP)

*Use this form to notify the Public Sector Workers' Compensation Program (PSWCP) and Employing Agency of your on-the-job injury and/or file a claim for Continuation of Pay (COP), if the injury places you out of work for three (3) or more days. (**COP is not Compensation. To make a claim for Compensation, you must file additional forms**).*

READ INSTRUCTIONS HERE AND ON THE REVERSE SIDE
For Help and Information, call (202) 727-8600

IMPORTANT: This form must be completed and submitted to the employee's immediate supervisor within **thirty (30) days** of the injury, disability or death and **MUST include a completed Form 4 and Form 5 to effectuate notice under D.C. Code § 1-623.19.** Failure to timely effectuate notice will result in denial of any claim for benefits, unless the requirements for a waiver are met under D.C. Code § 1-623.19(b) and 7 D.C.M.R. §§ 104.5 - 104.6. ***PSWCP will not authorize payment for medical expenses until a Claim for Compensation has been filed and accepted.*** **Visit http://www.orm.dc.gov for more information.**

SECTION I. EMPLOYEE INFORMATION

Claimant's Name:
Claimant's Full Address:
Street address
City State Zip
Claimant's Tel.:
Claimant's E-mail:
Employee SSN:
Employing Agency:
Supervisor Name:
Employee Occupation:
Employee Salary: ☐ Annual ☐ Hourly
Employee receive on-call pay? ☐ YES ☐ NO

Representative (if any):
Representative's Full Address:
Street address
City State Zip
Rep.'s Tel.:
Rep.'s Fax:
Rep.'s E-mail
Dependents: ☐ Spouse ☐ Other ☐ Children under 18 years
Employee ID No.:
Employee Grade: **Step:**
Seasonal Worker: ☐ YES ☐ NO

Employee Work Schedule:

Day	M	T	W	Th	F	Sat	Sun
Hours							
Shift (e.g. 9-5:30 p.m.)							

Employee Duties at the time of injury:
Employment Date with D.C. Government:

SECTION II. DESCRIPTION OF INJURY (Use additional paper if necessary)

Place where injury occurred (e.g. 2nd floor, One Judiciary Square, 16th and K Street NW)

Date of this Notice: _____ **Injury Date:** _____ **Time:** _____ ☐ a.m. ☐ p.m.

What was Employee doing at the time of the Injury?

Cause of Injury (Describe what happened, how you got injured, and why)

Nature of Injury (Identify both the injury and the part of body, e.g., sprain of right ankle)

Did someone other than the Employee cause the Injury? ☐ NO ☐ YES (If yes, explain below)

Were there witnesses to the incident? ☐ NO ☐ YES (If yes, complete following)

Witness Name: _____ Witness Name: _____

Contact Information: _____ Contact Information: _____

Has Employee sought medical care for injury? ☐ NO ☐ YES (If yes, complete following)

Date: _____ Provider Name: _____ Tel. _____

Provider Address: _____

Street Number City State Zip

SECTION III. DISABILITY STATUS / DEATH

Date Employee Stopped Working: _____ **Date of Death:** _____

Date Returned to Work: _____ ☐ Full Duty ☐ Modified Duty ☐ Part Time ☐ N/A

SECTION IV. EMPLOYEE CERTIFICATION

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 and that the injury described was sustained in performance of duty as an employee of the District of Columbia government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim the following, as checked below, while disabled for work:

☐ a. Continuation of regular pay (COP) not to exceed 21 days (or 45 days, if employed before January 1, 1980). If my claim for COP is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave. If my claim for compensation is later denied by the PSWCP, COP payments may be treated as a debt to the District under D.C. Code § 1-629.01 *et seq.*

☐ b. Sick and/or Annual Leave.

Signature of Employee or Representative _____ Date _____

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.

Claimant **MUST** file this form 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** **E-mail:** dcclaims@corvel.com

SUBMIT THIS FORM TO YOUR IMMEDIATE SUPERVISOR AND THE PSWCP.