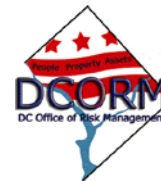




**GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT**



Jed Ross
Chief Risk Officer

**Public Sector Workers'
Compensation Program**

**FORM 2 – EMPLOYING AGENCY’S REPORT OF INJURY &
RESPONSE TO REQUEST FOR CONTINUATION OF PAY**

Use this form to report employee’s injury to the Public Sector Workers’ Compensation Program (PSWCP) and respond to Employee’s request for Continuation of Pay (COP).

READ INSTRUCTIONS HERE AND ON THE REVERSE SIDE

For Help and Information, call (202) 727-8600

IMPORTANT: Pursuant to 7 D.C.M.R. § 105.3, the Employing Agency (EA) **MUST** conduct an investigation, complete, and submit this form to the PSWCP by electronic mail at dcclaims@corvel.com within **THREE (3) days** of receipt of Form 1 from an employee. The EA **MUST ALSO** attach Form 1 to the e-mail.

SECTION I. EMPLOYING AGENCY INFORMATION

Agency Name: _____	Date: _____
Agency Address: _____	
<small>Street Address</small>	<small>City</small>
<small>State</small>	<small>ZIP</small>
Name of Person Completing this Form: _____	Title: _____

SECTION I. EMPLOYEE INFORMATION

Employee’s Name: _____	Employee’s DOB: _____
Date & Time of Injury: _____	Employee SSN: _____
Employee Occupation: _____	Supervisor Name: _____
Employee ID No.: _____	Supervisor Title: _____
Employee Grade: _____ Step: _____	Supervisor Tel.: _____
Date of Injury Pay Rate: \$ _____ per <input type="checkbox"/> Year <input type="checkbox"/> Hour	
Does employee receive on-call pay? <input type="checkbox"/> YES <input type="checkbox"/> NO Seasonal Worker: <input type="checkbox"/> YES <input type="checkbox"/> NO	

Regular Work Hours and Schedule:	Day	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
	No. of Hours							
	From:	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm
	To:	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm

Employee’s Duties: _____

Employee’s Duty Station: _____

Street Address City State ZIP

Date Employee started employment with D.C. Government: _____

Employee’s retirement coverage: ☐ CSRS ☐ 401a ☐ None ☐ Other (specify): _____

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

Has EA received Form 1?: ☐ YES ☐ NO **Form 1 Receipt Date:** _____

Did you witness the Injury? ☐ YES ☐ NO **If not, identify source:** _____

TURN OVER FOR MORE INSTRUCTIONS



Was an incident report prepared in connection with the injury? ☐ YES ☐ NO (If "YES," attach)

Did Employee report accident? ☐ YES ☐ NO If yes, to whom? _____

Date Employee reported accident: _____ Were there witnesses? ☐ NO ☐ YES, identify: _____

Witness Name: _____ Witness Name: _____

DC Employee? ☐ NO ☐ YES, Agency _____ DC Employee? ☐ NO ☐ YES, Agency _____

Street Address City State ZIP

Phone Number: _____

Street Address City State ZIP

Phone Number: _____

Was the employee injured in the performance of duty? ☐ YES ☐ NO (If "NO," explain below)

Was the injury caused by employee's willful misconduct, intoxication, or intent to injure self or another?

☐ YES ☐ NO (If "YES," explain): _____

Was the injury caused by a third party? ☐ NO ☐ YES (If "YES," explain and complete below)

Third party Name & Contact: _____

Street Address City State ZIP Telephone ()

Has Employee sought medical care for injury? ☐ NO ☐ YES, If "YES," Date: _____

Physician Name and Contact: _____

Street Address City State ZIP Telephone ()

Do medical reports show employee is disabled for work? ☐ NO ☐ YES Report Date: _____

Does your knowledge of the facts about this injury agree with the statements of the employee and/or witnesses? ☐ YES ☐ NO (If "NO," explain) _____

If the employing agency controverts continuation of pay (COP), state the reason in detail below.

Date Stopped Work: _____ Time: _____ am pm Date of Death (if fatal): _____

Date Pay Stopped: _____ Date COP began: _____

Pay rate when employee stopped work: \$ _____ per ☐ Year ☐ Hour

Date employee returned to work: _____ ☐ Full Duty ☐ Modified Duty ☐ Still Out

SECTION III. CERTIFICATION

I swear (or affirm) under penalty of perjury under the laws of the District of Columbia that the information provided above and that is furnished on the Employee's Form 1 is true and correct to the best of my knowledge with the exceptions described above.

Signature: _____ Date _____ Office Phone: _____

Filing Instructions:

(select one)

- ☐ No lost time and no medical expense: **Place this form in employee's medical folder**
☐ Lost time covered by leave, LWOP, or COP: **forward this form to the PSWCP**
☐ No lost time, medical expense incurred or expected: **forward this form to the PSWCP**

Form **MUST** be filed by via 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