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: _____
Street Address City State ZIP

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 ☐ Year ☐ Hour

Does employee receive on-call pay? ☐ YES ☐ NO **Seasonal Worker:** ☐ YES ☐ NO

Regular Work Hours and Schedule:

Day	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
No. of Hours							
From:	☐am ☐pm	☐am ☐pm	☐am ☐pm	☐am ☐pm	☐am ☐pm	☐am ☐pm	☐am ☐pm
To:	☐am ☐pm	☐am ☐pm	☐am ☐pm	☐am ☐pm	☐am ☐pm	☐am ☐pm	☐am ☐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
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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 Street Address City State ZIP

Phone Number: **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**