# Jed Ross

**Chief Risk Officer** 

#### GOVERNMENT OF THE DISTRICT OF COLUMBIA

#### OFFICE OF RISK MANAGEMENT



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 <a href="wcsecure@dc.gov">wcsecure@dc.gov</a> 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	Supervisor Name:					
Occupation:						
Employee ID	Supervisor Title:					
No.:						
Employee Grade: Step:	Supervisor Tel.:					
SECTION II. REPORT OF INJURY (Use additional pa	aper if necessary)					
Has EA received Form 1? YES NO	Form 1 Receipt Date:					
Did you witness the Injury?	If not, identify source:					
Date employee reported accident and to who was it reported to?						
Were there witnesses?	fy:					
Witness Name:	Witness Name:					
DC Employee?	cy DC Employee?					
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?

PSWCP Form 2

District of Columbia Government

YES NO (If "	YES," explain):				
Was the injury caus party?	sed by a third	□ NO □	YES (If "YE	ES," explain and comp	plete below)
Third party Name &	& Contact:				
				(	)
Street Address	City		State		elephone
Has employee been	taken out of work?	NO L	YES	On what Date:	
Has Employee soug	ht medical care for	injury?	□ NO □	YES, If "YES," Dat	te:
Physician Name and	d Contact:				
i nysician ivame and	u Contact.				
Street Address	City	7	State	ZIP Te	lephone
Success Fluid Costs			State	20 10	.cp.io.io
			gree with the s	statements of the em	ployee and/or
witnesses? YE	S NO (If "NO,"	explain)			
TC 41			(COD) 4	4.41	. 11 1 1 .
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