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 wcsecure@dc.gov 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.:**

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:**

Date employee reported accident and to who was it reported to?

Were there witnesses? ☐ NO ☐ YES, identify:

Witness Name: **Witness Name:**

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

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 been taken out of work? ☐ NO ☐ YES **On what Date:**

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

Physician Name and Contact:

Street Address City State ZIP ( ) Telephone

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:**

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: wcsecure@dc.gov**

SUBMIT THIS FORM TO YOUR IMMEDIATE SUPERVISOR AND THE PSWCP.