GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers' Compensation Program

FORM 3A – EMPLOYEE STATEMENT OF MEDICAL HISTORY

For Help and Information, call (202) 442-HELP (4357)

IMPORTANT: ***Completion and submission of this form is required to file a claim for benefits with the Program.***

SECTION I. EMPLOYEE INFORMATION

Name:

Telephone:

Address (with unit number, zip code):

E-mail :

Employing Agency:

Claim Number:

Last Four of SSN:

DOB:

Occupation:

Date of Injury/Illness:

Injured at:

Date Last Worked:

Date of First Exam:

SECTION II. MEDICAL HISTORY (Use additional paper if necessary)

Identify the name(s) of all of your family physician(s)/primary care physician(s) during the last ten (10) years.

Identify any healthcare professional(s) you are currently consulting and/or treating with for any of the injuries and/or damages you sustained as a direct result of the work injury, other than the physician who completed your Form 3.

Did the work injury aggravate a pre-existing condition? ☐ YES ☐ NO If "YES," complete the following:

(a) The nature and extent of such pre-existing condition

(b) The date upon which you believe you recovered from symptoms of the preexisting condition(s), prior to the work injury

(c) The name and address of the healthcare professional(s) who treated you for the pre-existing condition(s); and

(d) The date of and circumstances causing you to incur the pre-existing condition(s).

Did you sustain any injuries or suffer from any disease, deformity, or impairment to the areas injured as a result of the work injury before or after the date of the work injury, which in any way affected those parts of your body claimed to have been injured as a result of the work injury?

☐ YES ☐ NO If "YES," complete the following:

(a) Describe the nature and extent of any such injury, disease, deformity, or impairment.

(b) Identify the date of the occurrence or diagnosis of such injury, disease, deformity, or impairment;

(c) State the names and address(es) of the healthcare professional(s) you have consulted with and/or treated with and the corresponding dates of treatment or consultation for such injury, disease, deformity, or impairment.

(d) Did you lose time from work as a result of the injury, disease, deformity, or impairment?	☐ YES ☐ NO

(e) If you sustained any injuries as a result of the original work injury, describe the circumstances causing you to incur any such injuries.

SECTION III. 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.

Signature of Employee _____ 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 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) 442-HELP (4357)** **Email: wc.claims@dc.gov** **Fax: 202-535-1130**