GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers' Compensation Program

FORM CA7 – CLAIM FOR COMPENSATION

Use this form to file a claim for workers' compensation with the Public Sector Workers' Compensation Program.

READ INSTRUCTIONS HERE AND ON THE REVERSE SIDE
For Help and Information, call (202) 442-HELP (4357)

IMPORTANT: This form must be fully completed and submitted with Form 3, Form 3A, Form 4, and Form 5 for the claim to be deemed filed under D.C. Code 1-623.21. Claims must be filed within two years after the injury date to be compensable, unless exceptions provided at D.C. Code § 1-623.22(d) are satisfied. Please complete the shaded areas below.

SECTION I. EMPLOYEE INFORMATION

Claimant's Name: _____
Claimant's Full Address:

_____
Street address

_____
City State Zip

Claimant's Tel.: _____
Claimant's E-mail: _____
Last Four of Employee SSN: _____
Employee ID No.: _____
Date of Injury: _____

Representative (if any): _____
Representative's Full Address:

_____
Street address

_____
City State Zip

Rep.'s Tel.: _____
Rep.'s Fax: _____
Rep.'s E-mail _____
Employee Occupation: _____
Date Stopped Work: _____

SECTION II. COMPENSATION CLAIM

Compensation is claimed for:

☐ Wage-Loss (select type) for the corresponding date range

		From	To
a.	☐ Leave without pay	_____	_____
b.	☐ Leave buy back	_____	_____
c.	☐ Loss of wage earning capacity	_____	_____

Please explain: _____

☐ Medical Compensation

Is this the first Form CA-7 claim for compensation you have filed for this injury? ☐ NO ☐ YES

SECTION III. OUTSIDE EARNINGS

You must report any and all earnings from employment (outside your District government job); include any employment for which you received a salary, wages, income, sales commissions, or payment of any kind during the period(s) claimed in Section II. Include self-employment, odd jobs, involvement in business enterprises, as well as military service. **Have you worked outside your District government job for the period(s) claimed in Section II?** ☐ YES ☐ NO If "YES," complete below:

Name of Business: _____ Type of Work: _____

Address: _____

Address City State ZIP Code

Dates Worked**:** _____

SECTION IV. OTHER BENEFITS

Have you ever applied for or received payment under any Federal or District of Columbia Retirement or Disability law? ☐ NO ☐ YES If YES, complete below

Claim Number	Date Annuity Began	Amount of Monthly Payment	Retirement/Disability System
			☐ CSRS ☐ SSS ☐ DC ☐ Other: _____

SECTION V. DISABILITY STATUS

Has Employee sought medical care for injury? ☐ NO ☐ YES (If yes, complete following)

Date: _____ Provider Name: _____ Tel. _____

Provider Address: _____

Date Employee stopped work: _____ **Date of Death:** _____

Has employee returned to work? ☐ NO ☐ YES (If yes, complete following)

Date: ☐ Full Duty ☐ Modified Duty ☐ Part Time

SECTION VI. EMPLOYEE CERTIFICATION

I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the District of Columbia government. I swear (or affirm) under penalty of perjury under the laws of the District of Columbia that the information provided above is true and accurate to the best of my knowledge and belief. Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain compensation as provided by the Comprehensive Merit Personnel Act, or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a criminal conviction for fraud will result in denial or termination of all current and future PSWCP benefits. I understand that by signing this form, if evidence is received suggesting possible employment or earnings, I authorize the PSWCP to request verification of employment/earnings from the Social Security Administration.

Signature of Employee or Representative _____ Date _____