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) 727-8600

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.

PART A – EMPLOYEE PORTION

SECTION I. EMPLOYEE INFORMATION

Claimant's Name: ____________

Claimant's Full Address:

Street address

City State Zip

Claimant's Tel.: ____________

Claimant's E-mail: ____________

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

Claimant's Name:

List all persons you claim as dependents:

Dependent Name	Social Security #	Date of Birth	Relationship	Living with You?
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

For dependents not living with you, complete a and b below.

a. Are you making support payments for any dependent?
☐ YES ☐ NO If "YES," support payments are mailed to:

Name Address City State ZIP Code

b. Were support payments ordered by a court? ☐ YES ☐ NO If YES, attach copy of court order

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 with the military. Fraudulently concealing employment or failing to report income may result in forfeiture of compensation benefits and/or criminal prosecution. **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. THIRD PARTY CLAIM

Was or will there be a claim against a 3rd Party who caused the injury? ☐ NO ☐ YES

3rd Party Name: Date Filed:

If you are represented by an attorney, Attorney's Name:

Attorney's Address and Phone No.:

SECTION V. 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 VI. 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

Claimant's Name: ______

SECTION VII. 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 ______

SUBMIT THIS FORM TO YOUR IMMEDIATE SUPERVISOR AND THE PSWCP.

PART B – EMPLOYING AGENCY PORTION

SECTION VIII. EMPLOYEE EARNINGS INFORMATION

a. Date of Injury: ______

Grade: ______ **Step:** ______ **Base Pay** ______ **per** ______ **On-Call Pay** ______ **per** ______

b. Date Employee Stopped Work: ______

Grade: ______ **Step:** ______ **Base Pay** ______ **per** ______ **On-Call Pay** ______ **per** ______

SECTION IX. EMPLOYEE SCHEDULE

a. Does employee work a fixed 40-hour per week schedule? ☐ YES ☐ NO

If YES, mark scheduled days: ☐ Sun ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sat

If NO, fill in scheduled hours for the two week pay period in which work stopped.

Regular Work Hours and Schedule

	Day	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Week 1	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
Week 2	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

b. Did the Employee work in position for 11 months prior to injury? ☐ YES ☐ NO

Claimant's Name:

If No, would position have afforded employment for 11 months but for the injury? ☐ YES ☐ NO

SECTION X. BENEFITS

On date pay stopped, was employee enrolled in any of the following:

a. **Health Benefits** ☐ YES ☐ NO If YES, Provider & Plan:

b. **Basic Life Insurance:** ☐ YES ☐ NO

c. **Optional Life Insurance:** ☐ YES ☐ NO If YES, Class:

d. **Retirement System?** ☐ YES ☐ NO If YES, Plan:

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:

Did you witness the Injury? ☐ YES ☐ NO If NO, source of information:

Were there other witnesses? ☐ NO ☐ YES Identify:

SECTION XI. PAY STATUS FOR DISABILITY PERIOD

COP	**From**	/ /	**To**	/ /	☐ NO COP RECEIVED
Sick Leave	**From**	/ /	**To**	/ /	
Annual Leave	**From**	/ /	**To**	/ /	
Leave Without Pay	**From**	/ /	**To**	/ /	
Work	**From**	/ /	**To**	/ /	

SECTION XII. RETURN TO WORK

Did Employee Return to work? ☐ YES ☐ NO If "YES," date:

If returned, did employee return to the pre-date-of-injury job, with the same number of hours and the same duties? ☐ YES ☐ NO If "NO," explain:

SECTION XIII. REMARKS REGARDING EMPLOYEE REPRESENTATIONS IN PART A

SECTION XIV. EMPLOYING AGENCY CERTIFICATION

An employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact with respect to this claim (or impedes the filing of a claim) may also be subject to appropriate discipline and/or criminal prosecution. I certify that the information given above and that furnished by the employee on this form is true to the best of my knowledge, with any exceptions noted in Section XIII, Remarks, above.

Signature: Date Phone:

(Agency Official)

Name of Agency: Date Claim Form Received from Employee:

If PSWCP needs specific pay information, the person who should be contacted is:

Name: Title:

Telephone No.: Fax No.: E-mail:

Employing Agencies must submit this form to the Public Sector Workers' Compensation Program.