DEPARTMENT OF EMPLOYMENT SERVICES
OFFICE OF WORKERS' COMPENSATION
4058 MINNESOTA AVE. NE, SUITE 3802
WASHINGTON, DC 20019

QUARTER ENDING DATE: ________________
DATE OF REPORT: ______________________

CERTIFYING OFFICIAL (TYPE)

CERTIFYING OFFICIAL (SIGNATURE)

TITLE

TELEPHONE NUMBER

<table>
<thead>
<tr>
<th>CLAIMANT NAME</th>
<th>SOCIAL SECURITY #</th>
<th>OWC #</th>
<th>INJURY DATE</th>
<th>EMPLOYER ID #</th>
<th>N/L *</th>
<th>MEDICAL PAYMENTS</th>
<th>COMPENSATION PAYMENTS</th>
<th>VOCATIONAL REHAB. PAYMENTS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SUB TOTAL

TOTAL

* NO=NO LOSS TIME  L=LOSS TIME