District of Columbia Government
Office of Workers' Compensation
P.O. Box 56098
Washington, DC 20011
(202) 671-1000

Warning: *It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.*

Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

Wage Schedule

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

Employer must forward to insurer copies of this schedule no later than employee's tenth (10th) day of loss of wages.

This wage schedule is for 26 weeks prior to date of injury, for wages fixed by week, month, or year, and must be filed with Office of Workers' Compensation by insurer, together with Form No. 9 DCWC, except when maximum compensation is paid. ***(Wages: In addition to money payments, wages mean reasonable value of board, rent, and housing that were received from employer as well as gratuities declared for tax purposes.)***

Date of Hire: _____ Date of Injury: _____

Hourly Wages: _____ Average Weekly Earnings: _____

	1	2		3	4
Week Ending	**Gross Earnings**	**Other Advantages** (see wages definition above)	**Week Ending**	**Gross Earnings**	**Other Advantages** (see wages definition above)
1			**14**		
2			**15**		
3			**16**		
4			**17**		
5			**18**		
6			**19**		
7			**20**		
8			**21**		
9			**22**		
10			**23**		
11			**24**		
12			**25**		
13			**26**		

Total of columns 1,2,3 and 4 _____

If wages fixed by week, month, or year, state amount _____ per _____

_____ Representatives Name

_____ Signature